MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 27 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: D9 | HOSPITAL DAY: 10

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	2100	0400										
BP ARTERIAL LINE	/	/			/	/										
BP CUFF	86/50	88/51	90/50	90/56	101/64	93/59										
TEMPERATURE	98.0	98.5	99.0	98.3	99.0	98.5										
PULSE	64	82	76	86	79	71										
RESPIRATORY RATE	16	16	18	18	14	16										
OXYGEN (L/%)	/	/			/	/										
PULSE OXIMETER	100	98	99	97%	99%	100%										
O_2 METHOD	RA	RA	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:	0700	1600	2000					
PAIN INTENSITY (10 / 5 / 0)	0	2	0					
MED ADMINISTERED (Y/N)	N	Y						
RELIEF ACCEPTABLE (Y/N)	NA	Y						

OTHER

TIME:	0700							
FINGER STICK GLUCOSE	N/A							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0700	1600	2200
*Skin breakdown prevention	N/A		NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: N/A

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] D(4)-4

DIAGNOSIS: S/P (L) parietal skull fx c̄ epid hematoma

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: 0700 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.	☐ Ø 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.	☐ 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.	☐ staples to scalp intact, ± S/S of infection	☐ staples to (L) scalp incision intact No S/S infection	☐ (L) scalp c sutures & staples intact OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ Ø/10	☐ c/o HA Tylenol 650mg PO	☑
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: 0700 INITIALS: [redacted]	TIME: 1600 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: N/A	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:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2: N/O Access	IV Site #2: NO ACCESS
Comments: IV D/C'd in (R) FA.	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: OTO	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: 0700	1600	2300
ID band visible/legible	[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:
PERCENT CONSUMED: 50%	PERCENT CONSUMED: 75%	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: 0700 INITIALS: [redacted]	TIME: 1600 INITIAL [redacted]	TIME: INITIALS:
CONTENT: - plan of care - importance of nutrition	CONTENT: Plan of care	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	b(6)-2 SIGNATURE	SHIFT
CIV b(6)-4 [redacted]	[redacted]	[redacted] OUT/AN	06-14
		[redacted]	2
		[redacted] 91WMC	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1600	(L) scalp	staples intact No s/s infection	NA

SECTION IV - NOTES

1600: A&O x3. % HA. Tylenol 650mg PO given [redacted] 2400
continue to monitor. b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 28 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 10 | HOSPITAL DAY: 11

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:	1600	2000	1200	0400												
BP ARTERIAL LINE	/	/		/												
BP CUFF	83/53	101/61	90/60	82/50												
TEMPERATURE	98.6	98.2	98.2	99.1												
PULSE	76	73	66	70												
RESPIRATORY RATE	16	16	16	16												
OXYGEN (L/%)	/	/		/												
PULSE OXIMETER	99	100	99%	98%												
O2 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:	0730	1430	2330	200	0400			
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)		NA	N		N			
RELIEF ACCEPTABLE (Y/N)		NA	N/A		N/A			

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)	N/A							

SPECIAL NEEDS

TIME:	1430	0400
*Skin breakdown prevention	NA	N/A
*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

[redacted] b(6)-4

DIAGNOSIS: S/P (L) parietal skull fx c̄ epid-hematoma

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: b(6)-2 [redacted]

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: 1000 INITIALS: [redacted]	TIME: 1430 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.	☑ Does not speak english	☐ communication difficult. Speaks no English.	☐ language 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.	☑	☑	☑
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.	☑	☑ Little PO intake.	☑
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.	☑ Walks w/ assistance Ambulated x 1	☑	☐ resting in bed
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 & sutures intact to scalp ∅ drainage	☐ Incision to ⊖ scalp. Staples intact.	☐ ✗ Scalp incision
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: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed: Heplock	IV tubing changed: NO	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	IV Site #1:	IV Site #1:
IV Site #2: NO	IV Site #2: Access	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
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 / OTHER

TIME:	1000	1430	2300
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			
Notify MD abnormal labs			
Incontinent urine/stool		✓	
Linen change prn	[redacted]		
Turn/reposition q2h		[redacted]	
ROM q2h if immobile			
Antiembolic hose		✓	✓

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Shake	
PERCENT CONSUMED:	25%		
HOW TOLERATED:	well	well	
	☑ 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: 1430 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: Plan of Care; Importance of Eating	CONTENT:	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		
	[redacted]	[redacted]	D
		[redacted]	2
		[redacted]	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1430	(R) scalp	staples intact, No s/s infection.	
	23 00	(L) scalp	staples intact clean.	Ø. OTA

SECTION IV - NOTES

1430: Awake + Alert. No c/o pain or discomfort @ this time will continue to monitor. [redacted] RIA

b(6) ÷ 2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 29Sep03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 11 | HOSPITAL DAY: 12

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:																
BP ARTERIAL LINE																
BP CUFF																
TEMPERATURE																
PULSE																
RESPIRATORY RATE																
OXYGEN (L/%)																
PULSE OXIMETER																
O_2 METHOD																

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:	0700							
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)								

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

CIV [redacted] b(6)-4

afgan

DIAGNOSIS: s/p(L) parietal skull fx c epidural hematoma

DRG: _____ ADMISSION DATE: 18Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: Armando Tefe

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: 0900 INITIALS: [redacted]	TIME: INITIALS:	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.	☑ does not speak English Sutures/Staples removed from Scalp	☐	☐
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.	☐ unsteady gait at times	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐	☐
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: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ 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: NO ACCESS	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

CIV [redacted] b(4)-4

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:	0900		
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
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: Regular	TYPE:	TYPE:
PERCENT CONSUMED: 25%	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	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE b(6)-2	SHIFT
b(6)-4 CIV [redacted]	[redacted]	[redacted]	10

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1100 - Pt to RTD tent. Does not speak English. At times has unsteady gait. — [redacted] b(6)-2

CIV [redacted] b(6)-4

Emergency

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 20's HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): nkda 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): unknown

4. PROPOSED SURGICAL PROCEDURE:
craniotomy

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: see H+P Implants: ? Medications: ?
Jewelry removed: yes/no Family waiting: yes/no
ring

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

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

[redacted] b(6)-4

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

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

[redacted] CPT/AN 18 Sept 03 DATE

11. POSTOPERATIVE EVALUATION:

Brief Site:

Drsg:

Breathing: intubated

B(W)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/RN

DATE: 18 Sept 03 TIME: 2040

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 18 Sept 03 TIME:

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 CPT [redacted] b(6)-2

3. DATE 18 Sept 03 TIME PATIENT ARRIVED IN SUITE 2050

4. PATIENT IN ROOM TIME 2050 NUMBER Trauma-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPT [redacted]	RELIEF SCRUB	
	SPT [redacted] b(6)-2		
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: pt positioned on beanbag, left side up, axillary roll in place, head on sheets and foam donut, ⓡ arm on padded armboard + ⓛ arm on pillow, pillow between legs, all pressure areas padded, position approved by surgeon + anesthesia

8. SKIN PREPARATION

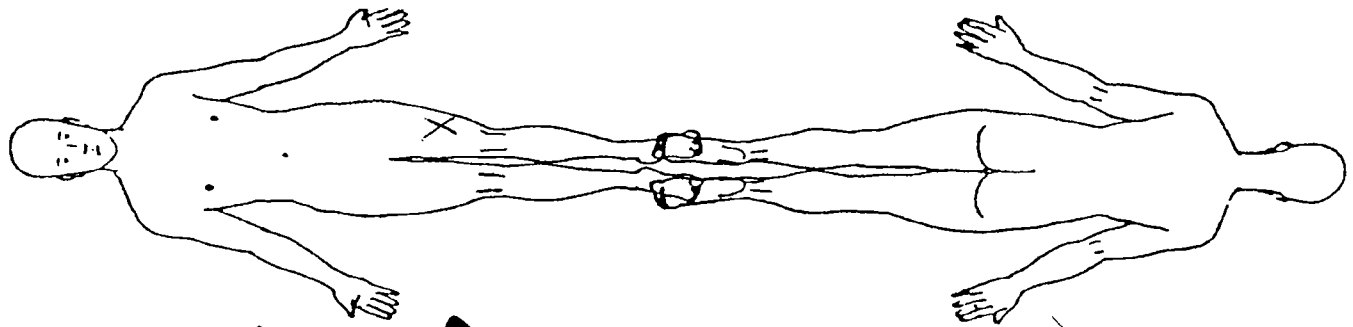
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☒ NURSING UNIT 1EMT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine/Betadine b(6)-2
SITE: Occipital + Temporal BY WHOM: [redacted]
SITE: left side head BY WHOM:

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

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

☒ ESU NO: Valleylab Force 2 #1
GROUND PAD: BRAND VL Rem Pliflexible II
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☒ BIPOLAR NO: Valleylab Force 2 #1

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

Craniofacial Plating System 81.2002 x 3 81.2054 x 1
Bioplate CMS 0222403
4mm screw 81.2058 x 19
5mm screw 81.2059 x 1

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Lidocaine c̄ Epi 1:100,000	15cc	I10	Inj	[redacted]	[redacted]
Thrombin 5000 u	QS	I10	Topical		
					b(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
Gelfoam	I10	[redacted]
Surgicel	I10	
		b(6)-2

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP Drain		
SITE	Posterior Head		

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Kerlix
Tape

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: Coag/Cut 50/50 → 35/35
Tourniquet Site intact pre-op _____: post-op_____
Tourniquet Time: Up____ Down_____ N/A

20. OPERATION(S) PERFORMED
Left Temporal Craniotomy for EDH

21. PATIENT TRANSFERRED TO ICU-1 (CT Scanner) TIME See DA7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT I. MEDCOM - 19456

REVERS[redacted]

USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Sep 2003 DAY 21 22 23 24 25 26

HOUR 12 20 00 12 00 12 00 12 00 12 00 12 00 12

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

C [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 Sep 2003	DAY	27		28		29													
19	HOUR	0700	8	1600	1	0													
PULSE (O)	TEMP. F (°)	0700	99	1600	2	4													TEMP. C
	105°				8	8													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

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO. ICW2

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

CIV [redacted]

b(6)-4

#[redacted] b(6)-4

ICU

SPECIMEN/LAB RPT. NO.

MISC

URGENCY
- [x] ROUTINE
- [ ] TODAY
- [ ] PRE-OP
- [ ] STAT

PATIENT STATUS
- [ ] BED
- [ ] AMB
- OUTPATIENT [ ]
- [ ] NP
- [ ] DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY MD TECH

DATE 19Sep03 0400

LAB ID NO.

REMARKS Coag, Chem 8

557-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS

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

#[redacted] b(6)-4

ICU

SPECIMEN/LAB RPT NO.

HEMATOLOGY

URGENCY
- [x] ROUTINE
- [ ] TODAY
- [ ] PRE-OP
- [ ] STAT

PATIENT STATUS
- [ ] BED
- [ ] AMB
- OUTPATIENT [ ]
- [ ] NP
- [ ] DOM

SPECIMEN SOURCE
- [ ] VEIN
- [ ] CAP
- [ ] OTHER (Specify)

PATIENT'S MED. RECORD

b(6)-2

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY MD TECH

DATE 19Sep03 0400

LAB. ID. NO.

REMARKS CBC

549-107

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

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

STANDARD FORM 545 (REV 10-75)
545-108

LABORATORY REPORT DISPLAY

20SEP03 0400

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____28 mmol/L

At 37C

PH_____7.512

PCO2_____33.5 mmHg

PO2_____187 mmHg

HCO3_____27 mmol/L

BEecf_____4 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

20SEP03 04:31

Oper: [redacted]

Physician:_____ b(6)-2

Ser# [redacted]

Ver: [redacted]

i-STAT EG7+ 1480 1800

Pt [redacted]

Pt Name:_____

Na_____140 mmol/L

K_____3.4 mmol/L

TCO2_____26 mmol/L

iCa_____1.18 mmol/L

Hct_____30 %PCV

Hb*_____10 g/dL

*via Hct

At 37C

PH_____7.461

PCO2_____34.7 mmHg

PO2_____191 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.453

PCO2_____35.6 mmHg

PO2_____194 mmHg

Patient Temp: 99.6F

FIO2_____: 40

Sample Type_: ART

19SEP03 18:01

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

① ② ③ ④

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted]

b(6)-4

FORMS DISPLAYED ON THIS SHEET

MOUNTED ON STRIPS 1 THROUGH 7

- ☐ CHEMISTRY I (SF 546)
- ☐ CHEMISTRY II (SF 547)
- ☐ CHEMISTRY III (SF 548)
- ☐ HEMATOLOGY (SF 549)
- ☐ URINALYSIS (SF 550)
- ☐ SEROLOGY (SF 551)
- ☐ SPINAL FLUID (SF 555)

☐ OTHER (Specify)

MOUNTED ON STRIPS 1, 4, AND 7

- ☐ MICROBIOLOGY I (SF 553)
- ☐ MICROBIOLOGY II (SF 554)
- ☐ MISCELLANEOUS (SF 557)
- ☐ ASSORTED FORMS

Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45, 505

LABORATORY REPORT DISPLAY

☆U.S. GOVERNMENT PRINTING OFFICE : 1990 267-126

======= PICCOLO =======
22/09/03 04:36
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: b(6)-2 3145AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	122*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CA++	9.0	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	137	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	101	98-108	MMOL
tCO2	23	18-33	MMOL

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

======= PICCOLO =======
19/09/03 04:12
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	182*	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	392*	39-380	U/L
NA+	136	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	113*	98-108	MMOL
tCO2	20	18-33	MMOL

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

======= PICCOLO =======
20/09/03 05:21
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] b(6)-2

GLU	137*	73-118	MG/DL
BUN	4*	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CRE	0.6	0.6-1.2	MG/DL
NA+	132	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	108	98-108	MMOL
tCO2	24	18-33	MMOL

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

[redacted] b(6)-4 ICU 1

MISC

URGENCY	PATIENT STATUS	SPECIMEN/LAB RPT. NO.
☐ ROUTINE	☐ BED ☐ AMB	
TODAY ☐	OUTPATIENT ☐	
☐ PRE-OP	☐ NP ☐ DOM	SPECIMEN SOURCE (Specify)
STAT ☐		

PHYSICIAN'S COPY

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

REQUESTING PHYSICIAN	REPORTED BY	DATE	LAB ID NO.
b(6)-2 [redacted]	MD / TECH	20 Sep 03	

REMARKS

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS

MISCELLANEOUS 557-107
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

Civ [redacted] b(6)-4 ICU 1

CHEM 1

URGENCY	PATIENT STATUS	SPECIMEN/LAB. RPT. NO.
☐ ROUTINE	☐ BED ☐ AMB	
TODAY ☐	OUTPATIENT ☐	
☐ PRE-OP	☐ NP ☐ DOM	SPECIMEN SOURCE
STAT ☐		☐ BLOOD

LABORATORY FILE

```
======= PICCOLO =======
21/09/03          04:19
REFERENCE RANGE:  b(6)-4  MALE
PATIENT #:  [redacted]
METLYTE 8
DISC UNIT #:  b(6)-4  3141AA4
OPER #:  [redacted]  DR #: 000
SERIAL #:  [redacted]
.....................
GLU   131*  73-118   MG/DL
BUN     3*   7-22    MG/DL
CRE   0.5*  0.6-1.2  MG/DL
CK    485*  39-380   U/L
NA+   132   128-145  MMOL
K+    3.4   3.3-4.7  MMOL
CL-   106   98-108   MMOL
tCO2  23    18-33    MMOL
INST QC: OK   CHEM QC: OK
HEM 0 , LIP 0 , ICT 0
```

Civ [redacted] b(4)-4

ICU 1

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PHYSICIAN COPY

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(4)-2

REPORTED BY MD TECH

DATE 21 Sep03

LAB. ID. NO.

REMARKS CBC, PT PTT

549-107

HEMATOLOGY STANDARD FORM 549 (Rev 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45.505

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PTT CONTROL	PTT PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
	21Sep	0340									WBC DIFF AND BLOOD CELL MORPH																					
	RESULTS																															

ICU 1

#7 [redacted] b(4)-4

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

b(4)-2

REPORTED BY MD TECH

DATE 20 Sep03 0400

LAB. ID. NO.

REMARKS

549-107

HEMATOLOGY STANDARD FORM 549 (Rev 7-78) PRESCRIBED BY GSA/ICMR FIRMR (41-CFR) 201-45.505

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #485 09/21/03 04:23 AM

Patient [redacted] b(a)-4
Test Name :PT
Test Result:= 12.4 sec.
RESULT NOT RANGE CHECKED
Ratio 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :09/21/03
Test Time :04:21 AM
Card Lot :010301
Operator :[redacted] b(a)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/21/03 04:26 AM

Patient ID 0/94
Test Name :APTT
Test Result:= 30.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/21/03
Test Time :04:23 AM
Card Lot
Operator

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

pH_____7.317

PCO2_____39.5 mmHg

PO2_____180 mmHg

HCO3_____20 mmol/L

BEecf_____-6 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

19SEP03 04:08

Oper: [redacted] b(w)-2

Physician:_____

Ser# [redacted]

Ver: [redacted]

P TREND 09/21/03

		SpO2	SYS / DIA - MEAN	RR
		%	mmHg	RPM
[illegible]		96	91 / 54	68	25
[illegible]		93	112 / 72	87	20
[illegible]		OFF	98 / 65	78	18
[illegible]		OFF	108 / 65	82	24
10:01	106	97	105 / 63	82	22
09:00	78	97	104 / 61	74	OFF
08:00	90	97	104 / 60	75	OFF
07:00	79	98	116 / 58	79	OFF

ADULT

PROTOCOL

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/19/03 04:15 AM

Patient ID: [redacted] b(w)-4
Test Name :PT
Test Result:= 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :04:13 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/19/03 04:18 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 39.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :04:15 AM
Card Lot :100208
Operator : [redacted]
b(w)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/20/03 04:55 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 0.99
Sample Type:citrated wh. blood
Test Date :09/20/03
Test Time :04:55 AM
Card Lot :010301
Operator : [redacted] b(w)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/20/03 05:00 AM

Patient ID: [redacted] b(w)-4
Test Name :APTT
Test Result:= 24.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/20/03
Test Time :04:57 AM
Card Lot :100208
Operator : [redacted]

[redacted] b(6)-4
ICW 2
Chem 7
22 Sept 03
0410

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: ☒ ROUTINE; TODAY ☐; ☐ PRE-OP; STAT ☐

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP; ☐ OTHER (Specify)

PATIENTS MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY MD TECH | DATE 22 Sept 03 | LAB. ID. NO.

REMARKS Chem 7

549-107

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

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/FMR
FIRMR (41-CFR) 201-45.505

ID: [redacted]
WB

20-09-03
04:56

			Patient Limits	
WBC	8.0	x10^3/uL	4.5	10.5
RBC	3.89 L	x10^6/uL	4.00	6.00
Hgb	11.4	g/dL	11.0	18.0
Hct	34.7 L	%	35.0	60.0
MCV	89.1	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	33.0	g/dL	33.0	37.0
Plt	175.	x10^3/uL	150.	450.
LY%	17.3 L	%	20.5	51.1
LY#	1.4	x10^3/uL	1.2	3.4

ID: [redacted]
WB

19-09-03
04:14

			Patient Limits	
WBC	10.1	x10^3/uL	4.5	10.5
RBC	3.98 L	x10^6/uL	4.00	6.00
Hgb	11.8	g/dL	11.0	18.0
Hct	35.7	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	29.5	pg	27.0	31.0
MCHC	32.9 L	g/dL	33.0	37.0
Plt	202.	x10^3/uL	150.	450.
LY%	12.7 *L	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

b(6)-2

Ward/Section: BMT OR	REQUESTING PHYSICIAN: DR. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE: 9/18/03 TIME: 2148	SSN/PSEUDO SSN: # [redacted] b(6)-4

i-STAT

TEST	RESULT	REF. RANGE

Pt Name: [redacted]

Na_____148 mmol/L
K_____3.7 mmol/L
TCO2_____19 mmol/L
iCa_____1.04 mmol/L
Hct_____30 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
pH_____7.392
PCO2_____29.1 mmHg
PO2_____487 mmHg
HCO3_____18 mmol/L
BEecf_____-7 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.392
PCO2_____29.1 mmHg
PO2_____487 mmHg

Patient Temp: 37.0C
FIO2_____100
Sample Type: ART

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST [redacted]	DATE 18 Sep 03 / TIME 1920	SSN/PSEUDO SSN: [redacted]

(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl

Pt: [redacted]

Pt Name:_____

Na_____145 mmol/L
K_____3.7 mmol/L
TCO2_____16 mmol/L
iCa_____1.00 mmol/L
Hct_____26 %PCV.
Hb*_____9 g/dL
*via Hct

At 37C
pH_____7.368
PCO2_____27.4 mmHg
PO2_____473 mmHg
HCO3_____16 mmol/L
BEecf_____-10 mmol/L
sO2*_____100 %
*calculated

At Patient Temp:
pH_____7.367
PCO2_____27.1 mmHg
PO2_____471 mmHg
Patient Temp: 36.7C
FIO2_____: 75
Sample Type:

18SEP03 22:27

Oper: [redacted]

Physician:_____

Ser# [redacted]

SR

======= PICCOLO =======
18/09/03 19:33
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-2
LIVER PANEL PLUS
DISC LOT #: 3122BA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	4.3	3.3-5.5	G/DL
ALP	75	26-84	U/L
ALT	26	10-47	U/L
AMY	48	14-97	U/L
AST	43*	11-38	U/L
TBIL	1.3	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	7.9	6.4-8.1	G/DL

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

======= PICCOLO =======
18/09/03 19:33
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: b(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	138*	73-118	MG/DL
BUN	26*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	541*	39-380	U/L
NA+	139	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

DATE:	LAB ID NO.:
18 Sep 03	

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

LAST, FIRST, MI. [redacted] b(6)-4	DATE 18 Sep 03	TIME 1920	SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		

ID: [redacted] 18-09-03
WB 19:38

			Patient Limits	
WBC	13.7 H	x10^3/uL	4.5	10.5
RBC	5.37	x10^6/uL	4.00	6.00
Hgb	15.6	g/dL	11.0	18.0
Hct	47.6	%	35.0	60.0
MCV	88.6	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	32.7 L	g/dL	33.0	37.0
Plt	282.	x10^3/uL	150.	450.
LY%	6.5 *L	%	20.5	51.1
LY#	0.9 *	x10^3/uL	1.2	3.4

(Hemato

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

REMARKS:

REPORTED BY:

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Hazy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	large	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	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

Actest - Large
Abc - 5-10
mucus - mod

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

nit Crossmatch
H EVERY UNIT OF BLOOD ESTED)

DE	CROSSMATCH

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 15.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated I[redacted]
Sample Type:citrated wh. blood
Test Date :09/18/03
Test Time :08:23 PM
Card Lot :010301
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/18/03 08:28 PM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 27.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/18/03

b(4)-4

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

LAST, FIRST,MI. # [redacted]		DATE 26 Sept 03	TIME 0400		SSN/PEEUDO SSN # [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		
GL		
BU		
CRI		
CK		
NA+		
K+		
CL-		
tCO2		

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
T		10-47 u/l
T		14-97 u/l
Y		11-38 u/l
L		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

======= PICCOLO =======
26/09/03 04:14
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: b(4)-2 3152AA4
OPER # [redacted] DR #: 000
SERIAL #: [redacted]

GLU	117	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	43	39-380	U/L
NA+	~~120*~~ 131	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	89*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

REMARKS:

REPORTED BY: **DATE**

Ward/Section: 1CW2	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. [redacted]	DATE 28 Sep 03	TIME 0710	SSN/PEEUDO SSN: #[redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8 Chem 7

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

(Piccolo) Metabolic Panel

```
======= PICCOLO =======
09/28/03                 07:57 AM
REFERENCE RANGE:          MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #:              3152AA4
OPER #: [redacted] u DR #: 000
SERIAL #: b(6)-4 [redacted]
.......................
GLU   109   73-118   MG/DL
BUN   10    7-22     MG/DL
CRE   0.9   0.6-1.2  MG/DL
CK    26*   39-380   U/L
NA+   118*  128-145  MMOL
K+    4.2   3.3-4.7  MMOL
CL-   92*   98-108   MMOL
tCO2  20    18-33    MMOL

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

CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	DATE: 9-28-03	LAB ID NO.:

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)												
Fentanyl (mcg)	50	<150>			50		50					
Lidocaine (mg)	100											
STP (mg)	500											
Succ (mg)	120											
Ufb (mg)		5 ~	5			5				5		
( )												
VOLAT AGENT — Iso % del		0.4	0.4	0.8	1.0	1.0	0.6	0.4	0.4	0.4	0.4	X
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	10~	2	2	2	2	2	2	2	2	2	2	10
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	P	P	P	P			P	P				

FLUIDS

LINE site												
14G (R) ☐ Warmed	NS #1						1000 #5-#7 LR		NS LR 2L			LR- 2L
18G (L) AC ☐ Warmed	LR #2								1000			
(R) IJ cordis 18G ☐ Warmed	NS #4						500 # 6 PRBC #1		2L NS			NS 5.3L
☐ Warmed	NS #3							P	400			

LOSSES

EST BLOOD LOSS							100					300
URINE -							700					

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT 70 (KG) LB

HEMATOCRIT

INITIAL DATA

BP- 75/34

HR- 115

EQUIP CHECK OK? - (Y) N

PATIENT RECHECK OK for PROCEDURE? JM

TIME- 2030

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

TIME → 2045 2100 . 30 . 2200 . 30 . 2300 : 30

PH				*7.39				*7.36	NS			
Na				143								
PCO_2	K	Blue		29.1	3.7			37.4				
PaO_2	ica+			487	104			473	120			MAPs 80-90s
BE				-7	30			-10	2			
SaO2	Hct			100				100				

VENTIL

VT - ml	800	800	810	810	810	820	810	830	810	810	810	800
f - breaths/min	14	11	11	11	11	11	11	11	10	10	7	10
Peak inf pres / PEEP	—	19	19	19	21	21	21	21	21	21	21	22
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	—	—	30	28	23	22	22	22	23	28	28	—
BP/oth — FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.0
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer — TEMP-site							Nasal 36.1	36.9	36.9	36.8	36.8	
N-M Block (T/4)		4/4			1/4		0/4		0/4	4/4	0/4	
BS	+	+										
Warming blkt	x1 wool blkt											
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (RLD turned 90°) (4) (5) (6)

TOTALS

300	
100	500
500	
120	
20	800

TOTAL EBL 500

TOTAL URINE 800

FLUIDS - SUMMARY

CRYSTALLOID- 4.5L

COLLOID- 0

BLOOD- 1 unit

REMARKS — Code drugs with numbers, events with letters

(1) Pre-op assessment Room monitor O2 Cricoid prep Induced Eyelids taped Closed. See airway management OG & Soft Cath Clock placed
(2) (R) radial A-line x1 attempt success
(3) Trendelenburg
(R) IJ
(4) PRBC #1
[redacted]
Drdyas @ BS.
(5) To CT; Acap seen by Surg Hematoma evacuated
(6) To ICU1 - Report
SIMV 10 800mL 10020 +5
P=Phenylephrine 100mg IV TIE

RECOVERY AT 2345

PACU (ICU) 1 (Specify)

OTHER

CONDITION: Stable

RESP. 10 SpO2- 100

BP- 124/70 HR- 88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2040	2050	2355
PROC	Ready	Begin	End
	2115	2150	2320

PROCEDURES and CPT Codes: (L) temp. craniotomy for EDH

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DLx1 MAC 4 grade 1 view 8.0 OETT stylETTed, +BBS Dust ETCO2

SURGEONS: [redacted] b(6)-2

ANESTHESIOLOGIST: [redacted] RNA/MA

PROCEDURE LOCATION: T

DATE: 18 Sept 03

PAGE 1 OF 1

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

ANESTHESIA PLAN OF CARE Pre-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: MVA - fell off vehicle
SURGICAL SERVICE:
NPO SINCE: ?

ASA Physical State 1 2 3 4 5 E
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: ?

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS: ?

CURRENT MEDICATIONS: Ø
( ) = ordered as premed

(✓) Ign and off
(✓) Lasix 10 mg IV
( ) 3 mg Ativan IV
(✓) Phenergan 25 mg
( )
( )

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

LABORATORY STUDIES:
HB/HCT: ____/____
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 94/51 HR 114 R 24 T ____
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: Coarse (=) B
CARDIAC: RRR tachycardic
EXTREMITIES:
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The pa[redacted] b(4)-2 to understand and agrees. Questions answered.
Signe[redacted] CRNA/MD Date: 18 Sept 03 Time: 2045 Hrs

PO[redacted]THESIA EVALUATION A[redacted] (NON ASU)
{ } [redacted]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) ____

CIV #[redacted] b(4)-4

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 18 Sep 03

DATE AND HOUR REQUIRED: ASAP

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

DIAGNOSIS OR OPERATIVE PROCEDURE: [redacted]

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)*

SIGNATURE OF VERIFIER: [redacted]

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: 18 Sep 03

TIME VERIFIED: 1920

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Compat

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

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

DONOR

ABO: O

Rh: neg

RECIPIENT

ABO: O

Rh: neg

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 18 Sep 03

REMARKS: exp 27 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)*: 2232 [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 recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*: [redacted] CRNA/MAJ

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

[redacted] CYOND

TEMP. [redacted] PULSE 84 BP 85/58

DATE OF TRANSFUSION: 18 Sept 03

TIME STARTED: 2240

POST-TRANSFUSION DATA

AMOUNT GIVEN: 300 ML

TIME/DATE COMPLETED/INTERRUPTED: 9-18-03 2300

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE: 36.8

PULSE: 92

BLOOD PRESSURE: 102/63

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 NOTIFIED: [redacted] CRNA

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

SEX: M

WARD: EWA

[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 - 19474

Medical Record Copy

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.
Head CT		M	754	EMT	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) Gonn				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED 18 Sep 93

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

Head Injury

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

RADIOLOGIC REPORT

1) ~~Mod~~ Small (L) parietooccip epidural fx 1cm thick acute/air

2) (L) parietal-occipital skull fx - disp 3mm extends into oblique (L) temporal fx.

3) (L) parietal SAH and intercerebral falx.

[redacted] b(6)-2

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

[redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

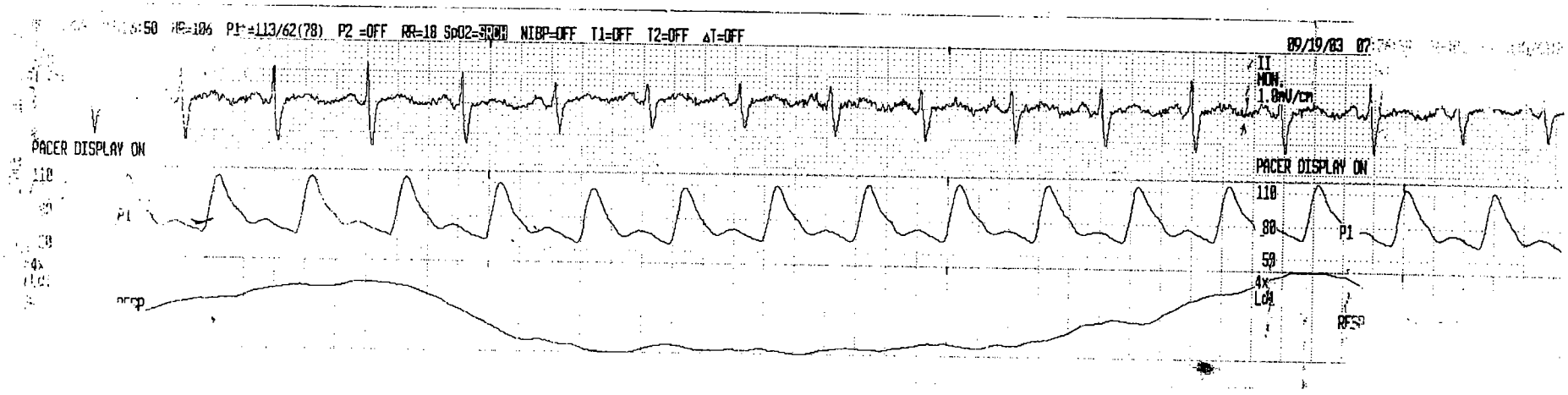
LOCATION OF RADIOLOGIC FACILITY

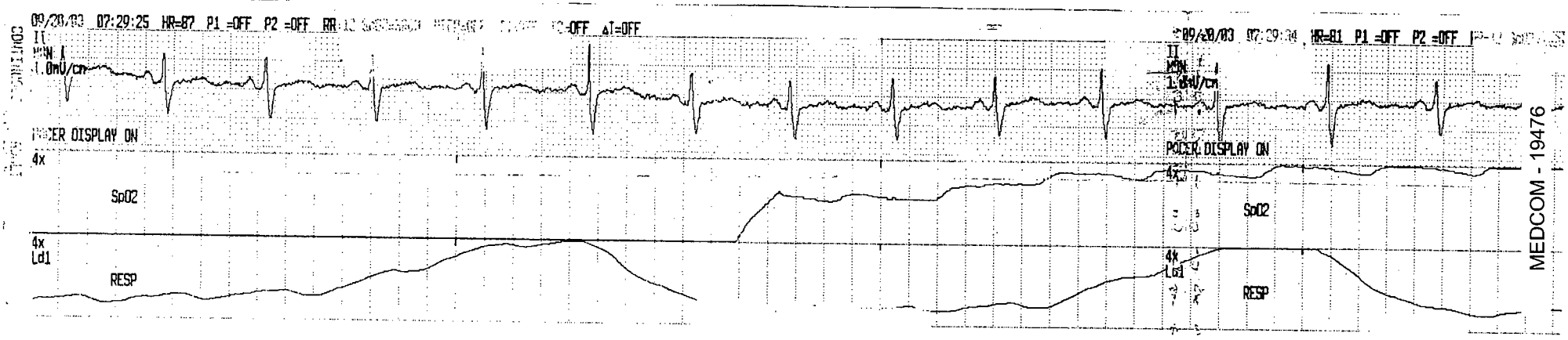
SIGNATURE

MEDCOM - 19475 TATION RT

2 — PHYSICIAN

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





MEDCOM - 19476

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 9/18/03 TIME OF ORDER 1945 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit ICU
(2) Dx: Basilar Skull Fx/Concussion Moderate
(3) HOB @ 30°
(4) Restraints due to Combativeness [redacted]
(5) IV D5 0.9 NS w/20 KCL @ 100 cc/hr
(6) PRN: Dilantin 100 mg q 8°
Ativan 1-2 mg q 4-6° for agitation

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(7) Foley to gravity
(8) Bed rest
(9) CBC, PT/PTT/Chem-7.
(10) NPO overnight
(11) On call CT-head.
[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF OR[redacted] ORDER

9/18/03 HOURS

(1) Admit to ICU
(2) DX: S/P Gun of EDH
(3) VS.
(4) HOB Flat D/C'd b(6)-2
(5) NPO
(6) ~~PRN~~ Dilantin 100mg IV q8°
(7) IV D5 0.9NS w/20 KCL @ 100 cc/hr

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(8) MSO4 1-2 mg ~~IV~~ for pain.
Foley Gravity
(9) Versed/Fentanyl [redacted] on Sedation [redacted]
(10) Ventilation: T[redacted] mode AC
[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9/18/03 TIME OF ORDER: 23:40 HOURS

LIST TIME ORDER NOTED AND SIGN

1. HOB @ 30°
2. versed 4mg/hr IV drip prn sedation
3. Fentanyl 100 mcg/hr IV drip prn sedation
4. Dilantin 100 mg IVPB q8°
5. CBC, PT, PTT, Chem 7 qam
6. ABG [redacted] 4 mis arg [redacted]
7. Ancef 1gm IVPB q8° [redacted]

PATIENT IDENTIFICATION

[redacted]

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

DATE OF ORDER: 9/19/03 TIME [redacted]

1. ↑ RR to 12 [redacted] b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 19 SEP TIME OF ORDER: 1720 HOURS

V.O ABG in 30 min

Dr [redacted] b(6)-2

Taken by [redacted]

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

1. D/C IV
2. Advance Clears

[redacted]

b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(4)-4 [redacted]

Noted 23SEP03 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/21/03 TIME OF ORDER 1300 HOURS | LIST TIME ORDER NOTED AND SIGN

(1). Tx to ICU
(2) pt: SIP (2) Parietal Skull Fracture
(3) w/ Epidural hematoma Evacuation
(4) Stable
(5) Vital c 4° of Neuro V/S
(6) NKDA
(7) Advance Clears Diet as tolerated

PATIENT IDENTIFICATION

b(4)-4 [redacted] b(4)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(8). Act: Sit-up in Chair w/ assistance only.
(9) D/C D5 0.9NS w/20 KCl @ 100cc/h
(10) Foley D/C.
(11). ~~CBC~~ chem 7 qod
PRN: Ancef 1gm IVPB x 8° x 2 doses.
Dilaudid 2-4mg po q4hs qd
(12). Ambulate w/ assistance [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted] HOURS

b(4)-2

24° Chart V [redacted] 9 Home 24Sept03 0005 [redacted] b(4)-2

PATIENT IDENTIFICATION

[redacted] b(4)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23SEP03 TIME OF ORDER 1154 HOURS

(1) T3 1-2 po q 4° pm Pain (Severe)
(2.) Tylenol 650 mg po q 4° pm (mild)

Noted 23SEP03 1200 [redacted]

[redacted] 4757 b(4)-2

b(4)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. b(4)-4 | BED NO.

24° Chart [redacted] 9 Home 24Sept03 0030 24° [redacted] 24Sept03 0310

b(4)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9/24 — TIME OF ORDER: _____ HOURS

D/C Dilantin [redacted] b(6)-2

D/C KCL. [redacted]

LIST TIME ORDER NOTED AND SIGN: Noted 24Sep03 0915 [redacted] MAJ/AN b(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9/24/03 — TIME OF ORDER: 0930 HOURS

Order Clarification: Advance diet as tolerated

VO Dr [redacted] MAJ/AN

Noted 24Sep03 0930 [redacted] MAJ/AN

[redacted]

24a chart [redacted] 9 Hum 25 Sept 03 0210 [redacted] 25Sep03 0430

PATIENT IDENTIFICATION: b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9/30/03 — TIME OF ORDER: 0809 HOURS

① D/C, to RTD

② Remove Sutures/Staples

[redacted] b(6)-2

Done Noted 9/30/03 0815 [redacted] MAJ/AN b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ___ 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
19Sep	[redacted]	VSI	06	[redacted]				
			18	[redacted]				
19Sep	[redacted]	NPO } DC 20Sep03	06	[redacted]				
			18	[redacted]				
19Sep	[redacted]	foley to gravity	06	[redacted]				
			18	[redacted]				
19Sep	[redacted]	Vent: TV800, RR-10, FiO2-40%, mode-AC	06	[redacted]				
			18	[redacted]				
19Sep	[redacted]	HOB 30°	06	[redacted]				
			18	[redacted]				
19Sep	[redacted]	CBC, CH7, PT/PTT qAM ABG qAM	04	[redacted]				
19Sep	[redacted]	↑ RR to 12	06	[redacted]				
			18	[redacted]				
20Sep	[redacted]	Advance clear diet	06	[redacted]				
			18	[redacted]				

} DC'd 20Sep03 2120

} DC'd 20Sep03 2120

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Evac of EDH

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(4)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Sep	[redacted]	Admit to ICU				
19Sep	[redacted]	BPG6 now				
17SEP	[redacted]	ABG 30 mins	19Sep	1745	1750	[redacted]
20SEP	[redacted]	D/C IJ access	20SEP	1600	1600	[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(4)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	21	22	23	24	25	26	27	28	29	30	1	2	3
21SEP03	[redacted]	Vitals q 4° c̄ NC	D	/	[redacted]											
			E													
			N													
21SEP03	[redacted]	Advance clears as tolerated	D	/	[redacted]											
			E													
			N													
21SEP03	[redacted]	Act: Sit-up in chair c̄ assistance only	D	/	[redacted]											
			E													
			N													
~~21SEP03~~	[redacted]	~~IV: D5 0.9NS c̄ 20KCl @100 cc/hr~~	~~D~~													
			~~E~~													
21SEP03	[redacted]	Chem 7 q Od	04	/	(D)	/	(D)	/	(D)	/	(D)	/		/		/
21SEP03	[redacted]	Ambulate c̄ assistance	D	/	[redacted]											
			E													
			N													
24Sep	[redacted]	Advance Diet as tolerated Regular	08	/	/	/	/	[redacted]								
			12	/	/	/	/									
			18	/	/	/	/									

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
S/P (R) Parietal skull Fx c̄ Epidural hematoma Evacuation

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

b(4)-2 A-1

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 04 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21SEP03	[redacted]	Transfer to ICW - stable	21SEP	Done		[redacted]
21SEP03	[redacted]	Foley DC.	21SEP	Done		[redacted]

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21
19 Sep	[redacted]	Pilantin 100 mg IV	03	/	[redacted]		
		q8°	11	/			
			19	/			
19 Sep	[redacted]	DS, 9NS ≅ 20K @	06	/	[redacted]		
		100 cc/hr	14	[redacted]			
19 Sep	[redacted]	Versed 4mg/hr W drip	06	/	[redacted]		
		prn sedation	18	[redacted]			
19 Sep	[redacted]	Fentanyl 100 mcg/hr	06	/	[redacted]		
		W gtt prn sedation	18	[redacted]			
19 Sep	[redacted]	Ancef 1gm IVPB q 8°	06	/	[redacted]		
			14	/			
			22	/			

DC'd 20Sep03 2120 MZZ

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Evac of EDH

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. _____ 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													
19Sep-	[redacted]	MSO4 1-2mg IV D														
- - - -	- - - - -	prn pain T														
- - - -	- - - - -	bid-2 I														
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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. 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
21SEP03	[redacted]	IV: D5 0.9NS c̄ 20Kcl	D	[redacted]						
		@ 100 cc/hr.	E	[redacted]						
			N	[redacted]						
21SEP03	[redacted]	Ancef 1gm IVPB x 8°	06	[redacted]						
		x 2 doses	22	[redacted]						
21SEP03	[redacted]	Dilantin 300mg PO qhs	20	[redacted]						
		qd.								
21Sep03	[redacted]	IV: D5 0.9NS @100/m	D	/	/	/	O	[redacted]		
		HL	E	/	/	/	[redacted]			
			N	/	/	/	[redacted]			

Md 24Sep03 L

Md 24Sep03 L

DC

ALLERGIES: ☐ YES ☑ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	s/p (L) Parietal skull Fx c̄ Epidural hematoma Evacuation	PAGE NO.

PATIENT IDENTIFICATION:

4B 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. 9 - 03

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23Sep 26Sep	[redacted]	Tylenol #3 1-2 po	23Sep 2 Tabs	25Sep 0935	25Sep 1600	26Sep 0800	26Sep 1830									
-----	-----	q 4° prn severe pain	1205	[redacted]		[redacted]										
23Sep	[redacted]	Tylenol 650mg po	0630	[redacted]		[redacted]										
-----	-----	q 4° prn mild pain	[redacted]			[redacted]										
-----	-----															
-----	-----	b(6)-2 An														
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D/C 29 Sep 03

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0600	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
	PUPILS	Perl 3mm Brisk					
	SENSORIUM	Alert oriented					
		Moves all extr					
RESPIRATORY	RESPIRATORY PATTERN	Reg Equal chest exp					
	BREATH SOUNDS	~~bilateral~~ clear to auscultation					
	SECRETIONS	Ø					
		Sat 97-100%					
		on Room Air.					
SKIN	COLOR	~~Cyanotic~~ Normal					
	INTEGRITY	Intact except for Surgical					
		Head incision and abrasions					
IV SITE	LOCATION	(L) Ac intact					
	CONDITION	(R) forearm intact &					
		DRESSING LOCKED at wrist					
GASTRO	ABDOMEN	Soft NANTender					
	BOWEL SOUNDS	BS(+)					
GU	URINE:	Foley					
	COLOR/CLARITY	clear yellow/Pink					
CARDIOVASCULAR	CARDIAC RHYTHM	SR. HR 70-80's					
		BP 102/64					
		Ø palpitations					
		Ø chest pain.					

LEGEND

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

b(6)-2

(Continue on reverse)

P[redacted] *(Signature & Title)* 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 21 Sep 03

[redacted] *(If typed or printed, written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

CiV [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 21 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	8	9	10	11	12	13	14
BP Arterial Line									
BP Cuff	102/64	114/58	104/60	106/61	105/65	108/65	98/65	112/72	91/54
Temperature	98.7			99.4			99.7		
Pulse	66	79	90	78	106	75	76	96	76
Respiratory Rate	24	21	22	22	22	24	18	20	24
Sat	98	97	97	97	97	off	98	95	96
	RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME									8° T	8° T
D5NS+Lasix	100	100	100	100	100	100	100	100	100	
IVPB	50					100			50	
TOTALS										

OUTPUT

URINE	HOUR	350	325						220										
	TOTAL																		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS							100												
STOOL																			
DRAINS																			
TOTALS																			

Haley DC

POST-OP DAY

VITAL SIGNS									

INTAKE										8° T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN / SUCTION										
	TIME									
TURN										
SUCTION										

24° I&O TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

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

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	09
EYES OPEN	SPONTANEOUSLY	4	4
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	
BEST VERBAL RESPONSE	ORIENTED	5	Made 2 arms, pt does not speak English
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	6
	LOCALIZES PAIN	5	
	FLEXION WITHDRAWAL	4	
	ABNORMAL FLEXION	3	
	EXTENSION TO PAIN	2	
	NO MOTOR RESPONSE	1	
LIMB MOVEMENT — ARMS	NORMAL POWER		6
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LIMB MOVEMENT — LEGS	NORMAL POWER		6
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
PUPILS — RIGHT	SIZE		3
	REACTION		+ +
PUPILS — LEFT	SIZE		3
	REACTION		+ +
PUPIL SCALE			● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm
ICP			
CEREBRAL PERFUSION PRESSURE			

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- + + Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

HOURS	
	R / L
	R / L
	R / L
	R / L
	R / L

LEGEND

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

b(4)-2

SHIFT ASSESSMENT

		TIME: 0610 INITIALS: [redacted]	TIME: 1900. INITIALS: [redacted]
NEURO	PUPILS	PERLA 3mm Brisk	PERRLA 3mm. Eyes are disconjugate.
	SENSORIUM	Moves extremities to pain and spontaneously	Pt is responsive to tactile stimuli.
	EXTREMITY MOVEMENT	Does not follow instructional question	Pt moves all 4 extremities in a non
	SEDATION	in english. Fent. 50mcg & Versed drip 2mg	purposeful manner. Pt is sedated
	PAIN CONTROL	MS04	c̄ 4mg/hr versed & 50mcg/hr
		[redacted]	fentanyl.
RESP	RESPIRATORY PATTERN	Vented. Intubated #8 ET 24cm @ lip	Intubated. #8.0 ETT, 24cm @ lip.
	BREATH SOUNDS	Bilateral breath sounds clear equal	vented AC 12, 40%, 800, 5. Peak pressure
	SECRETIONS	chest expansion. Suctioning of secretion	20-22cmH2O when pt not agitated. Breath
	O2 SOURCE/FLOW/SAO2	Blood tinge secretions draining from mouth	sounds clear bilat. SpO2 100%. Not
	VENTILATOR SETTINGS	TV 800 RR 10 FIO2 40% Resp A.C.	overbreathing vent. Equal chest expansion
CV	CARDIAC RHYTHM	SR HR 90's BP 108/60's S1S2	HR 80-90's. S1-S2. NSR.
	CAPILLARY REFILL	<3 sec	(+1) (B) LUE radial pulses, (+2) (B) pedal
	PULSES	All peripheral pulses (+)	Edema noted to (c) parietal area.
	EDEMA	(-) edema (-) JVD	cap refill <3 secs
		Cordis to (R) IJ	
		Alins to (R) Radial.	
GI	ABDOMEN	Abdomen Non distended Soft to touch.	Abd soft. BBS noted. OGT to LIS
	BOWEL SOUNDS	Hypo active.	c̄ green liquid drng.
	BOWEL MOVEMENT	Ø	
	NGT/OGT	OGT to intermittent suction	
	TUBE FEDDINGS	Ø	
	DRAINS	Ø	
GU	VOIDING	Foley	Foley to gravity drng clear light
	COLOR/CLARITY	Clear yellow	yellow urine.
SKIN	COLOR	Normal	large incision to (c) parietal area. Suture
	INTEGRITY	Intact. except for Head Surgical	intact.
		wound c̄ Staples (Intact)	
ACCESS	#1 TYPE/LOCATION/SIZE	Cordis (R) IJ	(R) IJ cordis. D5.9NS + 20K @ 100cc/hr
	DRESSING CONDITION	Intact	versed @ 40cc/hr, and fentanyl @
	IV FLUID/RATE	DFNI 20 + 1 at 100cc/hr (Fentanyl drip 50mcg Versed drip 2mg)	50c/hr infusing. Inserted 9/19/03
	#2 TYPE/LOCATION/SIZE	Left AC #18G (R) Forearm #14G	(R) FA 14G and (L) AC 18G PIV
	DRESSING CONDITION	Intact Intact	Saline locked. No drng. Flushes
	IV FLUIDS/RATE	(HL) (HL)	easily.

(Continue on reverse)

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

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

DATE: 19 Sep 03

(b)(2)-2

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

NAME: b(4)-4 RANK: AGE:

UNIT: # [redacted] 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

MEDCOM - 19493

USAPPC V2.00

ICU1

Patients Name: b(2) # [redacted]

Date: 19 SEP 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	108/61	108/63	112/58	out																						
NBP		95/61	97/61	96/60	89/55	95/62	97/60	93/63	95/62	94/61	97/65	96/63		99/61	103/65	103/62		100/62	103/60	110/72	106/67	99/68	105/66	105/65	104/61	
TEMP	99.1				98.6				98.1					99.6		99.1									98.3	
HR	98	97	95	96	83	83	99	95	92	94	98	91		86	90	82		82	85	86	85	88	77	81	78	
RR	10	10	10	15	10	10	10	10	10	10	10	10		12	12	13		13	13	13	12	12	12	12	12	
SaO2	100%	100	100	100	100	100	100	100	100	100	100	100		100	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	
FiO2	40%	40	40	40	40	40	40	40	40	40	40	40		40	40%	40%		40%	40%	40%	40%	40%	40%	40%	40%	
Source	SIMV	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC		AC	AC	AC		AC	AC	AC	AC	AC	AC	AC	AC	
MAP	75	76	76	74	68	75	73	74	75	74	77	75		75	80	77		77		76	78	77		79	77	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	12
IVPB	5D*						100		50				200				100	50					50			2
NGT																										
Versed	2	2	2	2	4	4	4	4	4	4	4	4	40	4	4	4	4	4	4	4	4	4	4	4	4	48
fentanyl	5	5	5	5	8	6	6	6	5	5	5	5	66	5	5	5	5	5	5	5	5	5	5	5	5	6
Total	157/157	107/264	107/371	107/478	112/590	110/700	210/910	110/1020	169/1189	109/1298	109/1407	109/1516		109/1625												

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	40/40	40/80	200/280	160/440	160/600	90/690	85/775	60/835	100/935	100/1035	120/1155	130/1285		200/1485	340/1825	100/1910		350/2260		350/2610	350/2960	115/3075	100/3175	324/3499	360/3859	3360
NGT															175	110		2160		2450	2700	2815	2975	3099	3360	
STOOL																										
DRAIN JP							25							25							25				20	95
Total	40/40	40/80	200/280	160/440	160/600	90/690	85/775	60/835	100/935	100/1035	120/1155	130/1285		225/1510												

MEDCOM - 19494

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	OTSG APPROVED *(Date)*
INTENSIVE CARE NURSING FLOW SHEET	QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0015. Initials: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils Sensorium LOC / GCS	2mm PERRLA. Pt is sedated and paralyzed from OR. Pt not moving extremities. S/p epidural hematoma.	
CARDIAC	Cardiac Rhythm PRI: / QRS: Pulse Strength Cap Refil / JVD Edema Chest Pain	S1-S2. Sinus rhythm. Rate 90's. +2 (B) pedal pulses, (+) 1 (R) radial pulse, (0) 2 (L) radial pulse. Cap refill <3 sec. ∅ edema noted.	
RESP	Respiratory Pattern Breath Sounds Secretions Cough	Intubated #8, 24cm @ lip. SIMV 10, TV 800, Peep 5, FiO2 100% initially then ↓ to 40% following ABG. SpO2 100%. Breath sounds clear bilat. Equal chest expansion. Peak pressures 20-22 cmH2O.	
SKIN	Color Integrity Backside	warm & dry. Staples to (L) parietal lobe intact. Bloody drng noted to gauze drsg. JP x 1 to (L) parietal lobe to bulb suction c̄ bloody drng.	
IV	Access Devices Location Condition	(R) IJ cordis c̄ fentanyl - 50mcg/hr, versed 4mg/hr, and D5 .9NS + 20KCl @ 100. (B) FA 14G PIV and (L) AC PIV saline locked. (R) radial A-line. Zeroed + leveled. Good square wave.	
GI	Abdomen Bowel Sounds Stoma/Ostomy	Not correlating c̄ NIBP. Abd soft. ∅ BS noted. OG tube to LIS. Placement verified via air bolus. to (L) UQ. Small amount clear brown drng noted.	
GU	Device Color / Clarity	Foley to gravity drng clear light yellow urine. >100cc/kg/hr.	

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU #1, [redacted] b(2)-2	18Sep03.

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

NAME: RANK: AGE:

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

ICU3

Patients Name: [redacted] b(w)-4 Date: 18 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																				125/71	112/58	104/59	102/60	105/62	104/61	
NBP																				98 8	91/55	85/57				
TEMP																				99	98 2	98 7			99 1	
HR																				89	97	99	96	98	94	
RR																				10	10	11	10	10	10	
SaO2																				100	100	100%	100%	100%	100%	
FiO2																				100	40	40%	40%	40%	40%	
Source																				V	Vent	Vent	Vent	Vent.	Vent	
M																				87	75	76	71	77		
																				~~87~~						

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF																				7500	100	100	100	100	100	80
IVPB																							100			10
NGT																					~~50~~					
Versed																					4	—	—	2	2	8
Fent																					5	—	—	5	5	15
PRBCs																				350 OR						
F																										
al																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
NE																			80 OR	1050	200+	2316	75	80	85	2126
NGT																					50					
STOOL																										
DRAIN JP																				65	~~60~~ 30		30		15	140
EBL																				500						500
Total																										

MEDCOM - 19496

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0615 Initals: [redacted]	Time: 1800 Initals: [redacted]
NEURO	Pupils	PERLA 2mm Brisk	PERRL Brisk
	Sensorium	Moves extremities to pain and	Moves all extremities
	LOC / GCS	Spontaneously. Does not follow	
		commands given in English	
CARDIAC	Cardiac Rhythm	SR HR 80's	S,S, normal no extra/murmurs
	PRI: / QRS:	.12	noted. Pulses palpable x 4
	Pulse Strength	all Peripheral pulses ⊕	
	Cap Refil / JVD	<3 ⊖ JVD	
	Edema	⊖ edema.	
	Chest Pain	unable to ascertain	
RESP	Respiratory Pattern	12 NOT Labored Vented	LUL not labored ⊖ equal
	Breath Sounds	clear & bilaterally equal chest exp	rise/fall of chest. Lung sounds
	Secretions	min	CTA bilat
	Cough	⊕ gag.	
SKIN	Color	Normal	NFR ⊖ similar to (L) side
	Integrity	Intact except for surgical wound	of hand.
	Backside	in head. Bruised backside	
IV	Access Devices	Cordis to (R) CVP - intact.	PIV ⊖ D5NS ⊖ 20 mg of KCL
	Location	(HC) to (L) ASC Intact	
	Condition	(HC) to (R) forearm intact.	
GI	Abdomen	Nondistended Soft rotund	(-) TRD (+) BS x 4 quad
	Bowel Sounds	BS hyperactive	
	Stoma/Ostomy	Ø	
GU	Device	foley	foley to gravity DS
	Color / Clarity	pale clear	clear yellow urine.

(Continue on reverse)

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

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

DATE 20 Sep 03.

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

NAME: #[redacted] RANK: AGE:

UNIT: b(6)-4 GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU3

Patients Name: # [redacted] b(6)

Date: 20 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	106/68	112/79	105/62	104/65	105/65	109/62	106/74	112/67	108/68	105/70	98/82	112/67		122/67	104/64	108/60	109/60	104/60	110/60	99/60	103/54	99/56	116/65	114/56		
TEMP	98.3			9	99				98.9						99.7		99.3									
HR	79	83	81	84	74	99	92	87	87	94	93	91		89	92	112	111	98	76	85	80	103	67	67	89	
RR	12	12	12	12	12	14	15	20	21	17	14	20		10	21	23	29	20	18	17	22	14	19	19	21	
SaO2	100%	100	100	100	100	100	100	100	100	100	100	98		97	94	94	97	97%	98	98%	99%	100%	97%	98%	98%	
FiO2	40%	40	40	40	40	40	6L	6L	6L	6L	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Source	AC	AC	AC	AC	AC	AC	NKM	NKM	NKM	NKM																
MAP	81	90	77	78	79	82	90	84	82	81	67	84														

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
IVPB	50					100			50									50					100			
NGT																										
Versed	4	4	2	2	2	2	Dc'd																			
Fent	5	5	5	5	3	0																				
PO Subtotal	159	109	107	107	105	202	100	100	150	100	100	100														
Total	159	268	375	482	587	819	819	919	1069	1169	1269	1369	1369													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
UPRINE	310	400	280	300	120	250	300	350	250	250	350	300		350	100	200	80	260	400	200	200	120	120	280	140	
NG																										
STOOL																										
DRAIN																										
Sub Total	310	400	280	300	120	250	300	350	250	250	350	300		350												
Total	310	710	960	1260	1380	1630	1930	2280	2530	2750	3100	3300	3300	3850												

MEDCOM - 19498

b(2)-2

ICU 1 burn unit [redacted] Iranian 8.0 ETT 24cm teeth

[redacted] **VENTILATOR FLOW SHEET**

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
19 Sep	0001	Simv	10	800	100	+5	22	10	92	100%	124/74	7.29	36.4	481	-9	18	100	MSK - A's to A/C, 40%
	0130	A/C	10	800	40	5	24	10	97	100	111/62							MSK
	0330	A/C	10	800	46	5	24	10	98	100	105/65							MSK
	0600	A/C	10	800	40	5	19	10	97	100	105/60	7.31	39.5	186	-6	20	100	MSK
	0800	A/C	10	800	40	5	28	30	114	100	125/72							BR
	1000	A/C	10	800	40	5	20	10	88	100	85/57							BR
	1200	A/C	10	800	40	5	22	10	88	100	97/60							BR
	1400	A/C	10	800	40	5	28	10	95	100	95/62							BR
	1600	A/C	10	800	40	5	24	10	99	100	90/61							RAA
	1800	A/C	12	800	40	5	23	12	93	100	112/70							RAA
	2000	A/C	12	800	40	5	22	12	91	100	118/76							RAA
	2200	A/C	12	800	40	5	22	12	91	100	103/62							RAA
20 Sep	0000	A/C	12	800	40	5	23	12	84	100	109/67							RAA
	0200	A/C	12	800	40	5	23	12	79	100	100/67							RAA
	0600	A/C	12	800	40	5	23	12	94	100	104/61							RAA
	0800	A/C	10	800	40	5	19	10	80	100	105/62							BR
	1000	A/C	12	800	40	5	20	12	77	100	104/65							BR
	1200	Pt extubated																BR

MEDCOM - 19499

EMERGENCY CARE AND TREATMENT (Medical Record) 21st CSH OP 01

1515

Treatment Facility: 21st CSH/EMT

BED #

ARRIVAL TIME: 18 Sep 03

DAY	MONTH	YEAR
18	Sep	03

TRANSPORTATION
Ground Tactical ☐ Air Rotary ☐
Ground Ambulance ☐ Air Fixed ☐
Other ☐

ALLERGIES: NKDA

MEDICATIONS: NONE

CHIEF COMPLAINT: Head Injury

PAIN SCALE (1-10)	TETANUS	SEX	AGE
		M	

NON-URGENT ☐ URGENT ☐ EMERGENT ☑ TIME SEEN BY PROVIDER:

VITAL SIGNS

TIME	1515	1548	1612	1705	1815	
BP	119/84	117/75	103/64		105/40	
PULSE	119	105	111	58	108	
RESP	10	16	19	20	19	
TEMP			98.7			
%O2	95		98	98	99	

ORDERS	INIT	TIME	PAIN
CBC Chem 7	[redacted]	1579	
Type & Cross	[redacted]	1579	
IV NS	[redacted]	1580	
Td 0.5cc IN	[redacted]	1820	

ASSESSMENT/DIAGNOSIS: R/O Concussion (Closed Head Injury)

DISPOSITION: HOME ☐ DUTY ☐ QTRS ☐ 24 ☐ 48 ☐ 72 MOD DUTY: UNTIL ____ REFERRED TO: ☐ ____ (Dispo) Stable Ex

EMERGENCY ☐ TODAY ☐ 72 HRS ☐ ROUTINE ☐

ADMITTED: ____ SERVICE: b(2)-2

CONDITION UPON RELEASE: To [redacted] By Neuro

IMPROVED ☐ UNCHANGED ☐ DETERIORATED ☐

TIME OF RELEASE: 1840

(8) IRANIAN ♂ Mid 20's victim of fall from LMTV. Uncertain as to height or whether vehicle was moving.

Neuro: GCS = 15
CN II-XII WNL
Pupils: PERRL (5 mm) (L ear)
(0) VSS; NAD; A+O×3
H: (L) superficial lac x2 (Ø suture) to occiput (+) Battle
E: Sclera clear
E: (R) TM mobile; (L) TM c̄ infection
N: Ø perf and medial wall loc 1mm. Hemostasis achieved.
T: Normal dentition
Ø LAD; Ø peritonsillar exudate/edema
Ø FOB

Lungs: CTA (B); Ø wheeze
CV: RRR; Ø M, G, R
Abdo: Soft; Ø tender; Ø mass; Ø bruit

X-RAY
C-Spine
T-Spine
L-Spine
Pelvis
Clear
Ø Fx

Abrasion ō soft tissue injury to (L) PSIS ō edema and (L) shoulder
Skin: Abrasion to (L) shoulder (R) PSIS Ø RASH.
GI: (-) GIAC

14/100 28 / 3.8 / 14 CA #28
18.1 / 17.1 / 345

PATIENTS IDENTIFICATION:

NAME/RANK: Iranian Civilian

SSN: IVAQL # [redacted]

DOB:

UNIT: b(6)-4

LOCATION:

PROVIDER SIGNATURE: [redacted] CPT, AN [redacted] Practice

INSTRUCTIONS TO PATIENT: Consult Surgery Service. b(6)-2

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN b(6)-4 Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. Iranian Civilian #[redacted]	DATE 18Sep03	TIME 1519	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	18.1	4.8-10.8 x 10^3
RBC	5.93	4.7-6.1 x 10^9
Hgb	17.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	53.3	42-52% (M) 37-47% (F)
MCV	89.9	80-94 fl (M) 81-99 fl (F)
Plt	345	130-500 x 10^3 verified
Lymph %	8.2	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
SG		N/A
pH		N/A
Leu		Negative
Nit		Negative
Pro		Negative
Glu		Negative
Ket		Negative
Ubg		0.2-1.0
Bil		Negative
Bld		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
Mono		Negative
RPR		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
HIV	Negative
Micro Parasites	
Malaria	
Other	
Serum HCG	

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS: CBCs, Chem 7, T+C

REPORTED BY: SPC [redacted] b(6)-2	DATE: 18 Sep 03	LAB ID NO.: 661

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

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU	111	73-118 mg/dl
BUN	28	7-22 mg/dl
CA^{++}	9.8	8.0-10.3 mg/dl
CRE	1.2	0.6-1.2 mg/dl
NA^+	141	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	100	98-108 mmol/l
tCO_2	22	18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

b(2)-2

18 Sept 03

[redacted] Hospital EMT Trauma Flow Sheet

Time of Arrival 1515
Name/Rank
Unit Civilian, Iranian
SSN:
DOB AGE: SEX M
Location of Unit:

Chief Complaint Head Injury
Time of C/C: LOC Duration
Transported by: (Air) Ground Amb Military Vehicle
Medications NONE
Allergies: NKDA

Airway ☑ Clear ☐ Obstructed Intubated ☐ Tube size
C Spine: ☑ Immobilized ☑ Cleared Time: 1622
Breathing: ☐ Normal ☑ Labored ☐ shallow ☐ assisted
☐ absent ☐ trach deviation
Circulation: IV's on Arrival UES x1 (D)AC
Pulses: Upper ☑ Lower ☑ Carotid ☑
Skin: ☐ Cool ☑ Dry ☐ Diaphoretic ☐ pale ☐ flushed
☐ mottled ☐ cyanotic pink
Chest: Breath Sounds: Clear ☑R ☑L
Decreased ☐ R ☐ L Absent ☐ R ☐ L Wheezing ☐ R ☐ L
Rales ☐ R ☐ L Ronchi ☐ R ☐ L
Moves upper Extremities ☑ Yes ☐ No Sensation ☐ Y ☐ N
Moves Lower Extremities: ☑ Yes ☐ No Sensation ☐ Y ☐ N

PROCEDURES

C Collar ☐ Backboard ☑ NG/OG _____FR Foley_____FR
CT_____FR ☐ L R ☐ Rectal Tone +____ --_____

O2 ☑ Device _____ %_____

Radiology: Time _____ XRAYS: Chest (C Spine)
~~AP~~ L-spine, Lateral skull, KUB

Labs: (CBC) (CHEM 7) Liver Panel UA T&C Units _____
OTHER
Monitor _____ EKG_____

MEDICATIONS/PROCEDURES DONE IN THE FIELD

C-collar in place, spinal immobilization
IV x1 (D)AC 18G c NS running

MEDS/FLUIDS	TIME	INIT	MEDS/FLUIDS	TIME	INIT
CBCs, Chem 7	1519	[redacted]	IV NS	1520	[redacted]
Type + Cross	1519	[redacted]	IV NS	1530	[redacted]
			Total In 1.0	Liter	

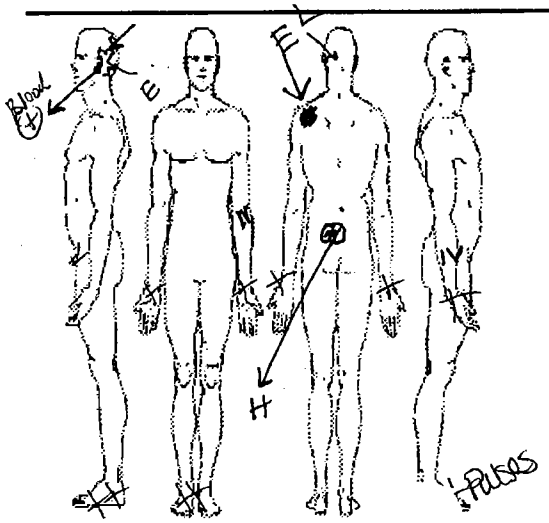
Time	1515		1548							
BP	119/84		117/75							
Pulse	129		105							
Resp	10		16							
Temp										
SAO2	95									
GCS										

NOTES

Blood in left ear canal
Guiac (Neg)
L spine series
Skull series
KUB
1622 C-Spine cleared
HPI: pt arrived to EMT s/p fall out of wo LMTV. GSC, +LOC on arrival. When interviewed present pt able to answer questions; able to identify self and place of birth; pt mildly combative; xrays completed without difficulty; VS stable throughout. c-spine cleared by CPT [redacted] 1715 pt sleeping in NAD; arousable to voice
Will continue to mt

CON'T NOTES ON REVERSE SIDE

A - Abrasion
AP - Amputation
AV - Avulsion
B - Burn
C - Contusion
DP - Decreased Pulse
E - Ecchymosis
F - Fracture Closed
FO - Fracture Open
IV--IV Lines
GSW - Gunshot Wound
H - Hematoma
L = Laceration
LS - Sutured
P - Pain
SW - Stab Wound
S - Scar
SP - Splint
T - Tenderness
SR- Shrapnel



MEDCOM - 19503 — [redacted] b(6)-2

GLASCOW COMA SCALE

1. Eye Opening:

Spontaneous	4
To Voice	3
To Pain	2
None	1

2. Verbal Response

Oriented	5
Confused	4
Inappropriate Words	3
Incomprehensible Words	2

3. Motor Response

Obeys Commands	6
Purposeful Movement	5
Withdraws (Pain)	4
Flexion (Pain)	3
Extension (Pain)	2
None	

GCS ON ARRIVAL 14

GLASCOW COMA SCALE (PEDIATRIC)

1. Eye Opening

Spontaneous	4
Speech	3
Pain	2
None	1

2. Best Verbal

Oriented, Smiles, Cries	5
Confused	4
Inapprop/inapprop cry	3
Incomprehensible/grunts	2
No response	1

3. Best Motor

Spontaneous	6
Localizes Pain	5
Withdraws to Pain	4
Decorticate (Flexion)	3
Decerebrate (Extension)	2
None	1

GCS ON ARRIVAL_____

NOTES (CON'T)

[redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF								LOCATION (State or Country Code.)
1	2	3	4	5	6	7	8	
A	[illegible]	1	D	1	[illegible]	I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
[redacted]										M

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
								4	0	y	Z	9	UNK

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
			NA	9	9	[redacted]								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	46: Z	1945	NA b(6)-4

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
			K	7	6									

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: O	ICU 1	UNK
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND [redacted] TREATMENT FACILITY: [redacted] b(2)-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYYYMMDD)							
73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88
5	0							2	0	0	3	0	9	3	0

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYYYMMDD)							
89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
A	B	A	A							2	0	0	3	0	9	1	8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (YYYYMMDD)							
107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122

FOR LOCAL USE

(L) PARIETAL SKULL FRACTURE
EPIDURAL HEMATOMA

DX 801.20
E817.1

PX 01.24
96.71
89.61
87.03
99.04

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

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6) -4

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) [redacted] (EPW)			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE 15	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC NA	9. EAS NA	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION NA		14. WARD ICW 1	
15. FLYING STATUS NA	16. RATING/ OSG	17. DEPT./ BRN NA 78		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: 2000	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk	25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: SEPT 20, 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): Unk	27b. TELEPHONE NO.: UNK	28. DATE OF THIS ADMISSION: SEPT 18 2003	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. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) THIGH

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	3	3

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	3	3

SIGNATURE OF [redacted] b(6)-2 Dr. [redacted] SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

b(6)-2

MEDICAL RECORD | 18 Sep 2008 | **ABBREVIATED MEDICAL RECORD**

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

15 y/o ♂ GSW (L) proximal thigh ~1500, 5.56 mm round
Med & allo PMH (-)

PHYSICAL EXAMINATION

WD ♂ alert NAD
HEENT (-)
neck (-)
ch clear ins & (A)
abd: soft but bladder distended to umbilicus
rectal - good tone, guaiac (+)

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

extr - wound all well nl mtx/sens tot'n LLE
XCNT DP/PT pulses bil
small medial proximal entry ~~small~~ large lat exit
compartments soft

b(6)-2

[redacted]

	DATE	IDENTIFICATION NO.	ORGANIZATION
	18 Sep		

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

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

Dr. ye Note

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE 18 Sep - 20 Sep '03 NOTES

Pt a 18 y/o male c GSW (L) proximal thigh from 5.56 mm round ~1500 18 Sep

Prev med & allo PMH neg

The wound, entry, is in proximal medial thigh with exit ~2 cm chandle on lateral proximal thigh. There was no fracture or neurovascular injury and the patient has bounding DP and PT pulses in the left lower extremity.

He was given tetanus toxoid and has been on Ancef since admission and will continue on 5 days PO cephalexin, to return if problems occur - fever, purulence, erythema, etc.

The wound margins were sharp debrided and the wound irrigated on admission.

b(6)-2 [redacted] MD LTC

[redacted] b(2)-2

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

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

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

[redacted] b(6)-4

EPW [redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18SEP03 2300	USS. AO. PERRLA. LSCTAB. HRR. (+) pulses to all extremities. DSG's to entry & exit wounds of (R) thigh CDI. Medial wound 1cm, beefy red. ¢ o/c. Exit wound to lateral (R) thigh 2.5 cm diameter, beefy red & sanguinous drainage. No c/o pain. IV AB and 100cc/hr LR. BS(+)x4. CR ≤2 secs. Cont to monitor — b(6)-2 [redacted] Arsen
19Sep03 0859	Received pt resting in bed, USS, A&O3, answers speaking. ¢ c/o pain. Dsg to (R) thigh intact w/ old drainage noted. Tol clear liquids. Foley pulled SWB 400cc clear light yellow urine. Tol diet when adv to reg, at 50% tray. IV d/c, ancef d/c. Heplock started. Dsg d'd, clean @ this time. Pulses LLE (+), feet warm & able to wiggle ¢ other remarkable assessments @ this time. Will cont to monitor pt. [redacted] b(6)-2
20sep03 0130	Assumed care @ 1800; AW USS, pt A&Ox3, [redacted] throughout, (+) pulses x4, brisk cap Ref; ¢ c/o pain @ this time; S.S2, LSCTA(B); (+) BS x4; all dsgs CDI & drainage; pt voiding QS, clear, yellow urine, ⊖ BM this shift; pt has been sleeping all shift, ⊖ difficulty communication; ⊖ Δ from above assessment; restraints in place; (+) circulation, ⊖ skin breakdown; cont to monitor — b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sept03 0900	VSS. Alert & Oriented. OOB to BR for AM Care. Consumed regular diet for breakfast. Lungs clear. BS(+)4 quad. Abd soft non-distended. PO Keflex tolerated well. Will continue plan of care. [redacted]
~~20Sept 1445~~	~~d/c to EPW Camp escorted by MP~~ [redacted]
20Sept 1445	D/C'ed to EPW Camp escorted by MP. [redacted] 2GM
	b(6)-2 & 11

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	2100 18 Sep
	Entrance/exit wounds debrided + irrigated at Ft Drum
	XR - ū frag or fx in pelvis + proximal femur
	P- admit for AB's + other [redacted]
19 Sep	1000
	Stable, wounds clean, dry Ht 37
	P- IVC fluids, po AB's, disch 20 Sep [redacted]
20 Sep	
	Stable, wounds clean, will disch c po cephalexin x 5 d
	b(6)-2 A-11 [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.

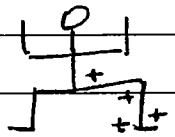
PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Sep 03	(S) 15 y/o Iraqi ♂ EPW brought in by 3/505 with GSW to (L) leg. Pt given 1L NS IV,
Al: Ø	1 Gram Ancef, 5mg Morphine by 3/505 medics.
Med: Ø	SURGERY
	As above. 15 y/o ♂ c̄ GSW (5.56 mm) (L) upper
B/P: 121/57	thigh. Only minimal to moderate blood loss
P: 63	at scene. VS as shown.
SpO2: 99	PE
	 pulses easily palpable, = (B).
	Through/through GSW medial → lateral thigh.
	Good ROM @ hip, knee, ankle 5/5 strength throughout.
	Minimal hematoma. Wound relatively clean.
	Plain XR femur s̄ evidence fracture.
	2° survey (−) for concurrent injuries.
A:	GSW (L) thigh.
P:	Will irrigate wound, IV Ancef b(6)-2
	Plan evac to CSH p̄ lavage. [redacted]
	CPT MC

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

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

Iraqi ♂

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 Sep 03	
16:50	(S) 15 y/o ♂ received gunshot wound to (L) thigh.
P 79	pt is stable (D) entry wound (D) exit wound, no arterial bleeding
R 16	good distal pulse. pt is Alert and calm
BP 120/78	
Temp	(O) GSW (D) lateral thigh c̄ exit wound Anterior Medial ~~upper~~
Allergies Ø	entry wound Approx 1.5 cm pt appears in pain Ø deformity (L) Thigh
O_2 sat 98	Ø crepitus Ø instability (L) thigh (+) good distal pulse (+) NVSI distal
	(P) ~~1000~~ 500 ml LR TKO, ↑ Full open @ 1730
	Morphine ~~5~~ 5 mg @ 18:40 IV Push
	Pressure dressing on both entry & exit wound
	Ancef ~~3gm~~ 1g IV Drip c̄ Normal Saline
1730	A: GSW (L) Thigh c̄ Exit wound
P 78	[redacted]
R 20	
BP 122/68	b(6)-2 SFC 91W4V
SpO_2 98%	[redacted]
	3/505 PA-C

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
3/505 BAS			
SPONSOR'S NAME: b(6)-4	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.

NAME: [redacted] RANK: _____

SSN: _____ DOB: 1988 AGE: 15

UNIT: _____ PHONE: _____

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

[redacted]
b(6)-4

b(2)-2

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 18/09/03 | TIME: 1958

TRANSPORTATION TO FACILITY: FLA

SEX: M

AGE: 15

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: NKDA

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

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

CHIEF COMPLAINT: GSW (L) THIGH

CATEGORY OF TREATMENT

☐ EMERGENT

☑ URGENT

☐ NON-URGENT

TIME: 1958

INITIALS: b(6)-2 [redacted]

VITAL SIGNS

TIME	1958	2040				
BP	102/40	127/61				
PULSE	84	79				
RESP	16	20				
TEMP	99.2					
WT		ox 100%				

LAB ORDERS

	CBC/DIFF		ABG		PT/PTT
	URINE C&S		UA MSCC/CATH		
	BLOOD C&S X				

BHCG/URINE/BLOOD/QUANT

CHEM:

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2000	1gm Ancef		[redacted]	2010	
2000	0.5 cc Tetanus			2010	b(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S) 18yo ♂ EPW presents c̄ GSW to (L) thigh. Minimal active bleeding (+) pulses distal to GSW. Pt states this happened around 1430-1500. ⊖ firmness in thigh. Wound has entrance & exit holes. → Rf

See Surgery H&P

⊖ TOB

PMHx ⊖

PSHx ⊖

T-T (L) thigh ∅ bony tend, N/V intact

UA 1.015 neg

A/P Clean GSW → Ab

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

GSW (L) thigh

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(w)-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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
18 Sept 03		1958	Pt arrived A/O X3, GSW's entrance + exit (2) thigh. VSS, ∅ arterial bleed, ∅ deformity. Rt [redacted] b(6)-2
		2010	2nd IV started, 16 Fr foley cath inserted to bladder. Blood + urine sent to lab. [redacted] b(6)-2
		2020	Pt transfered to X ray; Td 0.5 cc + Ancef 1 gm IV given. [redacted] b(6)-2
		2045	Surgeon debriding wounds, X ray done, VSS, Report given to ICW1. Lt [redacted] RN b(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	18SEP03		19Sept		20 Sept									
19	HOUR			07		10									

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	111/54		116/55		119/78									
		56			114/55										
		58		114/55	71.8										
	HEIGHT: WEIGHT →	57		76.5		98°C									

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.

E# [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

b(6)-2

TEST(S)
SPECIMEN TAKEN
DATE | TIME A.M. P.M.
REQUESTED
RESULTS

REMARKS [redacted]

REQUESTING PHYSICIAN'S SIGNATURE

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

REPORTED BY

MD DATE

TECH

ID: [redacted]
WB

19-09-03
04:56

			Patient Limits	
WBC	6.1	x10^3/uL	4.5	10.5
RBC	3.98 L	x10^6/uL	4.00	6.00
Hgb	12.5	g/dL	11.0	18.0
Hct	37.4	%	35.0	60.0
MCV	93.9	fL	80.0	99.9
MCH	31.5 H	pg	27.0	31.0
MCHC	33.6	g/dL	33.0	37.0
Plt	263.	x10^3/uL	150.	450.
LY%	32.5	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

ESC

TCW-1

[redacted]

b(6)-4

MISC

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

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

SPECIMEN SOURCE (Specify): Blood

LAB ID NO.

DATE: 9/9/03

SPECIMEN/LAB RPT. NO

PATIENT'S MED. RECORD

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

557-107

Stat

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW	DATE 18 Sept	TIME 2010	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	ID: [redacted] WB 18-09-03 20:23	
RBC		Patient Limits
Hgb	WBC 10.8 H x10^3/uL	4.5 10.5
	RBC 4.29 x10^6/uL	4.00 6.00
Hct	Hgb 13.4 g/dL	11.0 18.0
	Hct 40.7 %	35.0 60.0
MCV	MCV 94.9 fL	80.0 99.9
	MCH 31.2 H pg	27.0 31.0
Plt	MCHC 32.8 L g/dL	33.0 37.0
	Plt 306. x10^3/uL	150. 450.
Lymph %	LY% 16.4 *L %	20.5 51.1
	LY# 1.8 * x10^3/uL	1.2 3.4

(Hematology) Manual Differential

Segs		Mono	

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

Patient ID: [redacted] b(6)-2
Test Name :PT
Test Result:= 14.7 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR [redacted]
Sample Type:citrated wh. blood
Test Date :09/18/03
Test Time :08:30 PM
Card Lot :010301
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/18/03 08:34 PM

Patient ID: 795
Test Name :APTT
Test Result:= 32.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/18/03

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

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

(i-STAT)

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 (a 41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

PICCOLO
18/09/03 20:21
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
LIVER PANEL PLUS
DISC LOT #: 3122BA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.1	3.3-5.5	G/DL
ALP	201*	26-84	U/L
ALT	22	10-47	U/L
AMY	36	14-97	U/L
AST	41*	11-38	U/L
TBIL	1.0	0.2-1.6	MG/DL
GGT	6	5-65	U/L
TP	7.0	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
GLU		73-118 mg/dl
BUN		7-22 mg/dl

PICCOLO
18/09/03 20:21
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] b(6)-2

GLU	110	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	909*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	105	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

REMARKS:

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

b(6)-2

CLINICAL RECORD - DOCTOR ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

Noted & transcribed 18 Sep 03 2115 LT/AN

NURSING UNIT | ROOM NO | [redacted]

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

18 Sep 2000

Admit / GW

Vital stable

Diet - clear liq

IV LR 1000 / at 100 cc/h

Amy / gm IMB q 8h

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

MS 2-4 mg IV q 1-2 h prn pain

CBC am 19 Sep

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 chart [redacted] LT/AN 18 Sep 03 2115

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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]				19 Sep 1000 ____ HOURS	
			(1)	DC foley	
			(2)	DC Aders	
			(3)	Keflex 500 mg po q6h	
NURSING UNIT	ROOM NO.	BED NO.	(4)	ibuprofen 400 mg po q4h prn pain	
				[redacted]	
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF [redacted]	
			(5)	May sit in chair + ambulate	
			(6)	leg elev	
NURSING UNIT	ROOM NO.	BED NO.			
290	05SEP03	[redacted]			
PATIENT IDENTIFICATION				[redacted] ER / TIME OF ORDER	
				20 Sep 0700 ____ HOURS	
				dish pt today c̄ Keflex	
				[redacted]	
NURSING UNIT	ROOM NO.	BED NO.			
	20SEP03 0730				
PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
				____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

b(6)-2

Noted

b(6)-2 [redacted]

b(6)-2

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

b(4)-2 AN

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 18	19												
18Sep03	[redacted]	Diet = Clear Liquid	06-18	X	[redacted]												
			18-06														
18Sep03	[redacted]	NIO = Vitals Q shift	06-18	X	[redacted]												
			18-06														
19Sep03	[redacted]	May sit in chair &	06-18	/	[redacted]												
		ambulate	18-06	/													
19Sep03	[redacted]	Reg diet	06-18	/													
			18-06	/													

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
GSW (L) thigh

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 _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 Sep 03	[redacted]	Admit ICW 1	18 Sep [redacted]		b(6)-2	
18 Sep 03	[redacted]	Condition Stable	18 Se [redacted]			
18 Sep 03	[redacted]	CBC am 19 SEP	19 Sep [redacted]		0430	[redacted]
20 Sep 03	[redacted]	DC pt today c̄ Kaflex b(6)-2				

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

Medications

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 18	19	20	21
18Sep03	[redacted]	IV LR@ 100cc/hr	06	X	[redacted]		
			18				
			00				
18Sep03	[redacted]	Ancef 1gm IVPB Q8	08	X	[redacted]		
			16	X	/	D'cd 19Sep@1115	
			24	[redacted]	/		
19Sep03	[redacted]	Keflex 500mg po q6hr	06	/	[redacted]		
			12	/	[redacted]		
			18	/	[redacted]		
			24	/	[redacted]		

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW ⓛ thigh

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

PRN Medications

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
18 Sep 03	[redacted]	MSO4 2-4mg IV q1-2 HRS prn pain	D/T/I													
19 Sep 03		Ibuprofen 400mg po q4hr prn pain														

b(6)-2

USAPA V1.00

Pf: [redacted] b(6)-4

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 identified.
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
	20030918		

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
[redacted]	[redacted]	E-5

8. ORGANIZATION OR ADDRESS
Ace 3/505

9.
I, [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

We were conducting searches of home for illegal weapons. During the search of one of the homes we heard gunfire. SGT [redacted] reported back that he was fired upon and returned fire. In responce the entire Plt pushed to where SGT [redacted] was engaged. We found the Kid wounded about 100 meters from where SGT [redacted] said he was during the engagement.

[redacted] Nothing else Follows [redacted]

b(6)-2 All

10. EXHIBIT	11. INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 1 PAGES
	[redacted]	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT _____ TAKEN AT _____ DATED _____"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

038

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	1 5 y	2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	S	2000	NA b(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
I 2				✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW 1	UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION b(2)-2	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
5 0		2 0 0 3 0 9 2 0

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A B A A		2 0 0 3 0 9 1 8

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

FOR LOCAL USE

Dx: 8900
E9112
Trauma - 1
Injury - 450
Px: 8345
8659

890.0
E9121
86.59

ADMITTING OFFICER (Signature, as required): Dr. [redacted]

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW# [redacted] b(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 39	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION — b(6)-4		14. WARD ICU2	
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE W1A	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0120	23. CLINIC SERVICE AAAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE unk			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 19 Oct 03		b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) unk			27b. TELEPHONE NO. unk		28. DATE OF THIS ADMISSION 19 Sept 03		ADMITTING OFFICER Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to (R) flank/pelvis

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	31	31

36. Total Days All Facilites b(6)-2 [redacted]

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	[redacted]	0	0	31	31

SIGNATURE OF ATTENDING MEDICAL OFFI[redacted] [redacted]DICAL RECORDS OFFICER

Dr [redacted]

DA FO[redacted]

MEDCOM - 19529

USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME [redacted] EPW II [redacted] b(4)-4			GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 40	6. RACE —	7. RELIGION —	[redacted] SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICU	
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN K78		18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER					22. HOURS OF ADMISSION 0330	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk				25. TYPE DISPOSITION		26. DATE OF DISPOSITION 15 oct 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk				27b. TELEPHONE NO. unk		28. DATE OF THIS ADMISSION 7 OCT 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2						30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: s/p GSW to abn / Bilat lower lobe pneumo

35. Total Days This Facility

ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	8	8

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: Dr [redacted] MEDICAL RECORDS OFFICER [redacted]

b(4)-2

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

40 ish yo Iraqi male s/p GSW to (R) Flank
Presents with hypotension and combative

Meds
Ar~~tan~~ ?
Valium

PMH ?

All ?

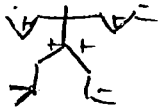
PSH ?

TOS ?

PHYSICAL EXAMINATION

NC AT (+) EtOH on breath.
Neck NT (-) deformity
Chest CBTA
Abd - ND (+) tenderness entrance wound (R) Flank.
Gu wnl
Rectal pelvis

Back Fluctuant Area @ Sacrum.
Ext (-) d/c/e
hypotensive



FAST (+)

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

A/P GSW to flank with tender abdomen and hypotension and (+) FAST -> TO OR for Ex CAP.

b(6)-2

[redacted]

	DATE	IDENTIFICATION NO.	ORGANIZATION
	19 Sep 03		

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

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10OCT03 (1655)	(cont) place ⅰ s/sx complications. Will continue to monitor. b(6) [redacted]
11OCT03 0042	VSS. AO. ∅ c/o pain. Speaking some audible appropriately. (R) to all orientities - BS (D) x4 - Steri strips remain intact to abdominal incision. ∅ s/s infection to abdomen. Resting comfortably in bed. Encouraged to use IS x 2 per 10 trials and completed well. 1.5 ↓ in (R) base. clear in (L) region. b(6)-2 [redacted]
11 Oct 03 0200	- Assumed care of pt. A+O x3. Midline incision to abd CDI ∅ s/s of infection No drainage noted. steri strips intact lungs clear diminished in bilat lower lobes. HRRR. IV site (C) PADS NS ⅰ 20 meq KCL @ 125 cc/hr oral flow applied. ∅ distress noted will cont to monitor. b(6)-2 [redacted]
	(1705) I concur ⅰ above assessment. [redacted]
11OCT03 @1940	VSS, O2 sats @97% on RA, lungs CTAB but ↓ lung fields diminished (B), HOB ↑ 30°, Steri strips to abd wound CDI, ∅ drainage noted, breakdown to sacral area - red & raw - duoderm applied CDI, Foley to gravity draining dark clear yellow urine, IV to (L) arm running D5NS ⅰ →

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

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

REGISTER NO. | WARD NO.

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	c̄ 20meq KCl ⊼ difficulty @ 125cc/. Continuing Primary IV around the clock, ∅ other remarkable findings. Continue to monitor for acute Δ's, X2 restraints, skin integrity intact. [redacted]
12 OCT 03 0200	- Assumed care of pt. A+O X3. VSS ∅ c/o pain or discomfort @ this time. Midline abdominal incision open to air healing secured c̄ steri strips. Lung clear BUL diminished in bases. HRRR. Active BS foley to gravity dark amber urine. PIV D5NS c̄ 20meq to (R) FA. Pt. remains afebrile IV ABX cont will cont to monitor [redacted]
12 Oct 03	@ 2100: VSS, A+O, O2 Sats @ 99%. RA, ∅ ⊼ resp distress, LCTAB but diminished in (R) lung field, HOB ↑ 30°, Continuing IS exercise ⊼ difficulty, IV to (L) FA infiltrated, D/C'd intact, restarted 22G to (R) FA running D5NS c̄ 20meq KCl @ D5cc/. Duoderm coming off to sacral wound (breakdown), applied new padded duoderm after cleaning area, X2 restraints, ⊖ skin breakdown, skin strips to midline abd wound CDI, Foley to gravity draining amber colored urine, ∅ other remarkable findings, continue to monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
19 Sep 2100	(L) subcl line placed. CXR in progress. OR, pulled back 2 cm; (R) femoral sheath removal [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
#[redacted] EPW 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 b(6)-2 A11
19 Sept 03 1130	Pt currently lying in bed sleeping. Pain medication effective. BP & maps in low 100's. Dr. [redacted] notified, will continue to monitor [redacted]
1230	Pt given Albumin 5% 500 cc per physician. Lab drawn & sent to lab as ordered. [redacted]
1330	1 unit PRBC ~~given~~ started, VS stable & temp of 98.5. Will continue to monitor [redacted]
1545	Blood complete. Pt resting comfortably in bed. Will continue to monitor [redacted]
1640	Pt given MSO4 4mg IVP for C/O pain. Abdominal drsgs clean, dry, & intact. [redacted]
2000	CBC, ABG SENT TO LAB. [redacted]
0000	CBC SENT TO LAB [redacted]
0030	PT RESTING COMFORTABLY. BED LINEN CHANGED AND PT ~~GIVEN~~. PARTIAL BATH. WILL CONTINUE TO MONITOR [redacted]
0230	PT PLACED ON O2 2L VIA NC FOR SC [redacted] 93-94% ON RA. WILL MONITOR [redacted]
20 SEP 03 (0700hrs)	Assumed care of patient @ 0615hrs & receiving S-of-shift report. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment. Resting comfortably in bed & noted distress/discomfort. Will receive 1u PRBC this a.m. See "Blood Transfusion" info on separate SF 509 & vital sign hx. IVF maintenance LR ↓ 150cc/hr [redacted]
20 Sep 03 (1100hrs)	IVF ΔD to D5½ & 20KCL 125cc/hr current bag of LR infuses. Blood transfusion x 1 unit completed. CBC via a line @ 1200hrs (post-transfusion). Lungs & rales throughout. SaO2: 95-96% & 2L O2 NC. Incentive x 10-20 reps q 1h performed. Productive greenish sputum noted. Apprehensive to cough/grunts abd. Abd. incisional now open to air & dressing removal by Dr [redacted] Incision (midline) & drainage → steri-strips. No substantial changes otherwise from initial assessment. Will push cough/deep breath [redacted]

STANDARD FORM 509 (REV. 6/1998) BACK

USAPA V1.00

[redacted]

b(6)-4

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 Sept. 03	Pt. admitted to ICU 2 from OR s/p Ex lap from GSW to
0505	abd. Neuro: A+O x 3. Rpils equal @ 2mm + reactive, brisk.
	Able to move extremeties x 4 equally. Resp: Resp. even, unlabored.
	lungs CTA throughout. SpO2 100% RA. RR 12-14. CV: HR regular.
	1+ pulses (B) LE, 2+ (B) UE. BP 83/44 c̄ MAP 59. Dr. [redacted] notified.
	Will monitor. (B) LE slightly elevated. Pre-op BP correlates. GI: Abd.
	soft, non tender to palpation. Hypoactive BS (R) UQ - otherwise absent.
	NGT to LIS (R) nare. Min. amt. of dark brown drainage. GU: Foley
	to gravity draining clear yellow urine. Drug tox. screen sent to lab.
	Skin: Midline abd. incision c̄ dressing CDI. Smaller incision on (R)
	side of abd. c̄ dressing CDI. Hemovac drain to midline incision
	c̄ 500cc bloody drainage emptied @ 0500. Lines: (R) radial A-line.
	(R) femoral cordis. 18g HL (L) AC. 18g PIV (R) AC c̄ LR @ 150 cc/hr
	infusing. [redacted] ILT/An
0515	NGT suction stopped. Multivitamin crushed + given via NGT. See
	PACU flowsheet for VS [redacted] ILT/An
0630	Pt received resting in bed. A+O x3. Moves all extremities
	appropriately. See PA 4700 for initial assessment. [redacted]
0730	Pt given bolus of 1000cc OR for MAPs in low 50's. Pt alert +
	oriented c̄ no change in mental status. [redacted] CPT/Ro
0915	Pt given MSO4 4mg IVP for c/o pain. Will continue to monitor [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW # [redacted]

b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 A11

DATE	NOTES
20 SEP 03 (0745hrs)	Blood transfusion 1u PRBC initiated as ordered for H/H 8.6 & 26.7 @ 0410hrs. Pre-transfusion
	vitals: T 98-103-31 104/65. Currently relaxed & s̄ noted distress. Will monitor closely
4825658	per transfusion protocol. [redacted]
0750hrs	vital signs: 98 ax - 106 - 32 115/73 ∅ s/sx adverse/anaphylactic reaction to transfusion. [redacted]
	Continue c̄ transfusion [redacted]
0755hrs	vital signs: 98 ax - 106 - 30 112/71 Continues to receive transfusion s̄ reaction [redacted]
~~0800hrs~~	~~Assumed care of patient @ 0615hrs p̄ receiving~~ [redacted]
0800hrs	VITALS: 98 ax - 106 - 30 - 112/71; Continue c̄ PRBC transfusion [redacted]
0815hrs	VITALS: 98 ax - 97 - 27 106/64; Continue c̄ PRBC transfusion [redacted]
0830hrs	VITALS: 98 ax - 101 - 25 - 108/66; PRBC transfusion continues [redacted]
0900hrs	VITALS: 98 ax - 107 - 28 - 119/74 - PRBC transfusion continues s̄ complications [redacted]
0930hrs	VITALS: 98 ax - 115 - 19 - 120/75 - PRBC transfusion continues [redacted]
1000hrs	VITALS: 98 ax - 110 - 26 - 101/69 - PRBC transfusion continues s̄ complications [redacted]
1030hrs	VITALS: 99 ax - 114 - 25 112/73 - ∅ urinalysis ∅ during transfusion [redacted]
1045hrs	Transfusion complete s̄ interruption. Final VS: 98 - 103 - 29 104/65. (L) AC heparin flushed. Will [redacted]
~~20 Sep~~	Monitor & obtain CBC @ 1200hrs [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

#[redacted] EPW

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	Surgery POD#2
	No events over night
	Tm 98.6 HR 100-110 RR 16-20 BP 100-120/70's
	UO - 75-100 cc/hr 6750 in / 3520 out.
	Hemovac ↓ ~40-50 cc/hr. Now cool and Appearing
	Clear CBTA
	CVS RRR 2+PP
	Abd Wound C/D/I Occasional BS @ ⓒ side
	NGT 400 x 24 hour bilious
	ext ⊖ c/c/e
	LABS 8.8 / 27 / 149 ABG 7.49/37/110/28/4.0 RA.
	127/106/15
	4.3/22/1.2
	A/P Doing well drainage ↓'d UO Adequate
	will ↓ IVF, cont NGT ↓ CBC to BID.
	[redacted] b(4)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 A11

DATE	NOTES
20 sep 03	Pt SaO_2 ↓ consistently @ 93-94%. Continues to have productive greenish sputum ↓
(1545hrs)	IS exercises. ↑ O_2 initially to 6L, ↑ SaO_2. Placed on mask c̄ O_2 @ 10l. SaO_2
	94-95%. SaO_2 ↓ 90-91% when weaned to 6l via mask. Will monitor and attempt [redacted]
	wean in 15min.
(1555hrs)	SaO_2 now 92-93% c̄ O_2 @ 10l c̄ mask. Switched to non-rebreather @ 10l. SaO_2
	unchanged. ↑ O_2 to 15l → SaO_2 95-96%. Patient RR 30-35/min. Lungs still
	c̄ rale sounds throughout, but denies difficulty breathing, ∅ chest pain. ~~Hungry~~ Will
	obtain portable chest x-ray and inform Dr. Bergman [redacted]
(1620hrs)	Informed Dr [redacted] during rounds of SaO_2 ↓. Awaiting x-ray for CXR. Will obtain
	ABG now via a line. SaO_2 currently 93% on 15l O_2 via non-rebreather. ∅ SOB
	∅ difficulty breathing. Monitor and await further orders. [redacted]
(1640hrs)	ABG results: [redacted]
	Dr [redacted] to consult c̄ radiology regarding CXR [redacted]
(1650hrs)	Patient to CT in EMT for R/O PE scan [redacted]
(1715hrs)	Patient set-up for CT scan (Total body) R/O PE protocol. SaO_2 95% on NRB c̄ O_2 @ 10-15l
	Will monitor while procedure is performed. [redacted]
(1750hrs)	CT scan completed. Dr [redacted] requesting an ~~d~~ ultrasound of ~~the~~ (B) LE veins to further R/O
	PE. Patient remains stable, SaO_2 @ 95%. ∅ SOB or difficulty breathing. HR 120's
	To ultrasound via litter. [redacted]
(1815hrs)	Ultrasound completed of (B) LE deep veins. (unremarkable findings). To the unit to receive
	heparin 1,000u IV bolus, then Heparin drip. Also neb tx's q4° c̄ suction every other neb [redacted]

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

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

REGISTER NO.	WARD NO.

[redacted] EPW

b(6)-4

PROGRESS NOTES
Medical Record

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[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
0006 21 Sept 03	rd. on 50% venturi mask since 2200 on 21 Sept begin @ 1600 hrs from 18 real time 1800 hrs schedule q 4 hrs 04-08-12-1600-2000-2400 hrs every other suction pt spits up copious amounts of green to tan sputum suction oral nasal pharynx also gets out moderate amount of secretions positive w/ suctioning diffuse (R)-(L) bronchi. pt still shows bad improved ability to 50% — O2 sats 97% Ds incentive cough [redacted] b(6)-2 [redacted] with decreased amounts noted in removal sent @ 1900 hrs otherwise
2000 21 Sept 03 — 21 Sept 03	RT note: Pt awake. Pre tx HR 110, RR 24, SPO2 99 on 50% venturi mask. BBS CTA ↓ on L>R. UD Alb given. Post tx HR 113, RR 28, SPO2 100% on 40%. nasal pharyngeal sx <3cc thick whitish. (+) productive cough. Will continue to monitor - [redacted] b(6)-2

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DATE	NOTES b(6)-2 A-1
21 Sep 03 (0615hrs)	Assumed care of patient p̄ D-of-shift report. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment. Pt. currently resting comfortably in bed s̄ [redacted] N/A
(0815)	Received nebulizer breathing treat as ordered. Tolerated nasal/trached suctioning well s̄ ↓ SaO_2. Currently SaO_2 99% c̄ 40% Venturi mask. Shows no indications of resp compromise c̄ RR 29. Will pack incentive spirometer q̄ 1° and monitor [redacted] N/A
(0820hrs)	Order for portable CXR received from Dr [redacted] Portable CXR completed. Continues ō Venturi mask (40%) ventilation ō SaO_2 99%, ∅ SOB or difficulty breathing. Plan to obtain sputum for cultures & gram p̄ Neph nebulizer tx via nasal suction & sputum catch. [redacted] N/A
(1121hrs)	ABG drawn via (D) Radial wrist stick per Dr. [redacted] Results: PH-7.46, PCO_2-36.1, PO_2-71 TCO_2-27, HCO_3-26, SO_2-95, BE-2. SaO_2 97% per Venturi mask @ 40%. Will D/C to nasal cannula @ 4L p̄ 1200hr nebulizer treatment & suction. [redacted] N/A
(1215h)	Tolerated 1200hr nebulize respiratory tx s̄ compromise or de-SAT. Sputum specimen obtained and dropped off @ microbiology. Pt switched to NC @ 4L. Current SaO_2 @ 98%. Plan to sit up in chair this afternoon. [redacted] N/A
21 Sep 03 (1230hrs)	Addendum Note: Pt given 4mg MSO_4 IVP for (P) flank discomfort & (P) LE discomfort. No significant changes to GI/GU or mental status since initial assessment. (+) facial grimacing & held (P) flank of abdomen, as well as rubbing (R) thigh. Given @ 0915hrs. [redacted] N/A

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

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

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[redacted] EPW

b(6)-4

PROGRESS NOTES
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b(6) - 2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 Sep 03 (1530hrs)	CBC drawn from ⓡ sc ~~cath~~ triple lumen c̄ problems. Await results from LAB [redacted] /AN
21 Sep 03 (1555hrs)	CBC results c̄ H&H 8.7/26.5 WBC 6.8. Results reviewed by Dr [redacted] /AN
21 Sep 03 (1615hrs)	Pt c̄ SaO_2 now 94-95%. Lungs c̄ improved breath sounds, but still c̄ scattered rales. ⊘ production cough (green sputum). Received nebulizer tx & nasal/tracheal suctioning; stimulated cough c̄ ↑ production of sputum expectorated. RR now 28 rpm and SaO_2 99-100%. ⊘ respiratory distress/difficulty breathing. [redacted] /AN
21 Sep 03 (1620hrs)	Given MSO4 4mg IVP for ⓡ flank discomfort & analgesic prep prior to getting in chair. RR-31 SAO_2-99% c̄ 4L O_2 NC. Plan to get patient up to chair within next hour [redacted] /AN
21 Sep 03 (1730hrs)	Pt OOB to chair on first attempt. Weight bearing fair (L) > (R). Has movement to (R) LE, but poor weight bearing. SaO_2 > 95% c̄ 4L O_2 NC while sitting in chair. Tolerating OOB very well. RR ↓ to mid/high 20's. ⊘ SOB or difficulty breathing displayed. Spontaneous, intermittent productive cough. Plan to leave pt. up in chair and give S-of-shift report @ 1800hrs. [redacted] /AN
22 Sept 03 0015	RT note: Pre tx HR 110, RR 25, SpO_2 95 on 2 LNC. BBS ⊘ A. Nurse took pt off tx, RT called to EMT for trauma [redacted]
22 Sept 03 0615	Assumed care of pt @ night shift, report given by [redacted]. Nasal airway to (R) nare intact. O_2 @ 4L/Min per NC. See assessment sheet. Will cont. to monitor. [redacted]
22 Sept 03 0630	DC'd (L) AC IV. Cath intact. Applied 2x2's & applied pressure. Secured c̄ tape. Will cont. to monitor [redacted]
0700	FS used approx 10-12 ys. Pt ball raised (1 cm per sec). Will cont. to monitor [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
~~1000~~ 0950	SPO2 ↓ 89%. NC A'd to simple face mask ↑ O2 @
22 Sept 03	6L/Min per simple face Mask. SPO2 ↑ 96%. Will [redacted]
	cont. to monitor.
1030	AM Lab RBC 2.75, Hgb 7.9, Hct 24.3. CBC redrawn & sent b(6)-2 A11
	to lab.
1130	CBC: RBC 2.68, Hgb 7.7 & Hct 23.9 MD notified of lab
	work. New orders recieved @ 1200 to transfuse 2
	u PRBC & Cont. Neb q 6°. Blood drawn & sent [redacted]
	to lab for type & cross. Will cont. to monitor
1350	DSG A'd on Femoral. large amt drainage noted. Applied
	4x4's. Secured c tape. Will cont. to monitor
	[redacted]
~~1400~~ 1405	1408 T 98.9 T, 101, 119/78 1st Unit PRBC started. Will cont
	to monitor. Lung sound (R) wheezing noted ↑ & ↓ lobes.
	(L) diminished noted ↑ & ↓ lobes. Will cont. to monitor
	O2 @ 6L/Min per face mask (simple) [redacted]
1405	T 98.6 T, 116/71, R 27, SPO2 100%, P 103. Will monitor [redacted]
1410	BP 119/73, T 98.8, P 101, R 25, SPO2 97%. Lung sounds: (R) wheezing noted
	↑ & ↓ lobes. (L) diminished ↓ & ↑ lobes. Will cont. to monitor [redacted]
1415	T 98.8 T, P 99, SPO2 99%, BP 115/71, R 23. b(6)-2 [redacted]

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

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

REGISTER NO.	WARD NO.

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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USAPA V1.00

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 Sept 83	
1420	T 99.4 T, P104, SPO2 96%, BP 119/76, R 22 [redacted]
1425	T 99.1 T, P101, SPO2 96%, BP 120/73, R 29 [redacted]
1430	T 99.1 T, P98, SPO2 98%, BP 115/71, R 20 [redacted]
1445	T 99.2 T, P101, SPO2 97%, BP 120/74, R 18 [redacted]
1500	T 99.3 T, P105, SPO2 95%, BP 121/76, R 24 [redacted]
1530	T 99.3 T, P103, SPO2 97%, BP 117/71, R 32 [redacted]
1554 1600	T 99 T, P100, SPO2 96%, BP 115/73, R 34 1st unit PRBC complete. Will Monitor. Holy + clear yellow urine. LS (L) slight wheezing noted ↑ + ↓ lobes. (R) diminished ↑ + ↓ lobes noted. Will cont to Monitor [redacted]
1620	2nd U PRBC started. VS before starting T 98 T, 100 P, BP 121/80
22 Sept 83	
1625	T 98.8 T, P105, SPO2 99%, BP 125/80, R 41 [redacted]
1630	T 98.6 T, P99, SPO2 100%, BP 121/79, R 26 [redacted]
1635	T 98.6 T, P100, SPO2 99%, BP 121/73, R 25 [redacted]
1640	T 98.5 T, P101, SPO2 99%, BP 122/71, R 29 [redacted]
1645	T 98.7 T, P101, SPO2 98%, BP 121/79, R 20 [redacted]
1650	T 99.3 T, P102, SPO2 99%, BP 120/76, R 25 [redacted]
1655	T 99.1 T, P102, SPO2 100%, BP 120/76, R 20 [redacted]
1720	T 99.6 T, P105, SPO2 98%, BP 107/80, R 33 [redacted]
1750	T 99 T, P102, SPO2 98%, BP 122/77, R 26 [redacted]
1820	T 99 T P 106 SPO2 99% BP 118/71 R 32 [redacted] 91WM
1822	blood transfusion over. am. labs to be done [redacted] 91WM
2200 2250	blood sent for a.m. labs [redacted]
2400	showed lab results to Dr. Bergman approved. [redacted]
0400	pt continues to ventilate breath with cough & suction [redacted]
	breathing for a.m. Oxygen [redacted] 91WM

09 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23 Sept 03 0030	RT note: Pt awake. BBS coarse c̄ slight wheezing LUR + ↓↓ @ bases. Pre tx 108 HR, RR 30, SpO_2 98% on 6L SM. UD Alb neb given. Post tx HR 117, RR 30, SpO_2 95% on 6L: Pt encouraged to deep breath. Pt moving about in bed (restless). BBS still coarse p̄ tx. Will continue to monitor [redacted] b(6)-2
23 Sept 03 0605	RT note: Pt asleep but easily awaken. BBS coarse c̄ faint wheezes. diminished @ bases. Pre tx HR 111, RR 16; SpO_2 98% on 10L SM. UD Alb tx given. Post tx HR 106, RR 26, SpO_2 98 on 6L SM. Sx to help pt cough. Advise pt to deep breath. Will continue to monitor. pt placed back on 6L SM. [redacted]
23 Sept 03 0630	- Received PT asleep in bed. VSS c̄ spo2 @ 97 on 6L Simple face mask. BBS coarse c̄ ⊖ Respiratory distress noted. PT coughing crusty colored sputum. Will attempt to get pt to drain and encourage incentive spirometer use. Pt tolerated neb treatment well. Distal cannula line flushes well, but gives no blood return. Use proximal line instead. Will cont to monitor pt for any respiratory change [redacted] b(6)-2 Cpt
23 Sept 03 0900	- Pt Given 20mg Lasix as per MD. Pt is Alto on Non-Rebreather mask @ 10L spo2 91%. sitting up on chair. Will cont to monitor pt. [redacted] Cpt b(6)-2

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

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

[redacted]
b(6)-4

PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1999)
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b(a)-4

EPW. [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
23 SEPT 03 1015	~~1015~~ @ PT SpO2 @ 98% on supp free NRC AT 10L. STILL encourage PT to cough + Deep Breath. Placed PT Back in bed for comfort. will cont to monitor for change. [redacted] b(a)-2
23 SEPT 03 1430	- PT is currently on simple face mask 6L SAT 97-95%. PT having ⊖ Respiratory distress. PT still sounds congested bilaterally. Also tolerated neb treatment well. PT is currently ~~sitting~~ Axiled @ AT 45° head of bed, resting comfortably c̄ ⊖ % pain. will cont to monitor for Δ's. [redacted] b(a)-2
23 SEPT 03 1730	- PT is currently on nasal cannula 2L O2. SAT 97%. ⊖ Respiratory distress or discomfort. will cont to monitor [redacted] b(a)-2
2000	NT SUCTION C̄ WHITISH YELLOW SPUTUM. PT ⊕ GAG REFLEX COUGH UP WHITISH YELLOW SPUTUM. SaO2 ↓ TO 89%. PT PLACED ON SFM @ 8L. WILL MONITOR. [redacted]
2200	ALERT 1GM GIVEN; ATIVAN 1MG GIVEN. NT SUCTION C̄ WHITISH THICK FROTHY SPUTUM. PT COUGHED UP THE SAME. SFM ↓ TO 6L. WILL MONITOR. [redacted] b(a)-2
2300	VSS - PT C̄ C/O PAIN MEDICATED C̄ 2MG MSO4 IVP. PT SaO2 97% - 96%. AFTER REDUCING TO 6L SFM. WILL CONTINUE TO MONITOR. [redacted]
24 SEPT 03 0000	NT SUCTION C̄ WHITISH THICK SPUTUM. ⊖ ORAL FROM PT. SaO2 96% on 6L SFM. WILL MONITOR. [redacted]
0200	NT SUCTION C̄ WHITISH FROTHY SECRETIONS ⊖ ORAL [redacted] PT PLACED ON NC @ 4L. O2 SATS @ 99 ON 6L SFM @ THIS TIME. WILL CONTINUE TO MONITOR AND TITRATE [redacted] b(a)
0400	VSS AFEBRILE. LABS SENT. PT RECEIVED MSO4 2MG FOR C/O ABD ⊕ V. PT UTILIZING I/S. BY 2° PROMPTING. SAFETY PT [redacted] WILL CONTINUE TO

b(a)-4 [redacted]

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0600	REPORT GIVEN TO SGT [redacted]. VSS AFEBRILE. PT SUCTIONED VIA NT C̄ SM AMOUNT WHITE THICK SECRETIONS. PT RN 2½L NC SaO2 @ 96%. [redacted]
24SEPT 03 0600	- Received PT Alert [redacted] verbal stimuli, awake in bed. ⊖ c/o pain or discomfort. B.lateral rise + fall of chest c̄ clear sounds on upper lungs. PT is currently on 4L NC SaO2 97%. ⊖ Respiratory distress at current time. Pulse present on all extremity c̄ good RCM. +3 sec cap ref. Heparin on (R) side currently drained ~~drainage~~ 10cc Bright red blood. ⊖ s/s of infection noted & site is CDI. PT's Foley drains clear color urine. Call escalate PT to rise to chair today & ambulate + Deep breath. [redacted]
24SEPT 03 1635	- MD reviewed PT Heparin. PT has ⊖ c/o pain or discomfort. Will continue to monitor [redacted]
1815	Received report from SGT [redacted]. VSS, temp 101.5. Neb treatment given by RT @ this time. SaO2 100%. HOB @ 45°. Nasal transport to (R) nostril for suctioning. Unable to flush proximal or distal port of subclavian lines. RT placed pt. on NC @ 4LPM, SaO2 of 96%, will continue to monitor. -SPC [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2100	O_2 reduced to 2LPM via NC, SaO_2 @ 98%, will continue to monitor ——— SPC [redacted]
2200	Pt. up to bedside chair, copious amounts of light green phlegm were coughed up by pt. SaO_2 ↓ to 82-84 percent, simple face mask put on @ 8LPM + 10LPM, SaO_2 remained below 86%. Pt. returned to bed + put on non-rebreather face mask. SaO_2 increased to 100% @ this time. Pt. suctioned through nasal trumpet, SaO_2 remained at 98% ⊕, simple face mask put back on @ 6Lpm ∴ SaO_2 remaining above 98%. Will continue to monitor. ——— SPC [redacted]
0030	Pt. placed on NC @ 4LPM, SaO_2 98% ——— SPC [redacted]
0200	O_2 turned off, pt on RA. SaO_2 @ 99%, will continue to monitor ——— SP [redacted]
0440	Pt. suctioned + put on simple mask @ 6LPM for SaO_2 ↓ to 84%, SaO_2 ↑ to 94%, will continue to monitor SPC [redacted]
0600	Assumed care of pt. VSS. will continue to monitor. SPC [redacted]
1630	MD made rounds @ bedside. Dr. [redacted] weaning pt to wean off O_2 from FM to NC. pt fully awake, cooperative, calm. D/C ⓡ nasal trumpet. D/C FM @ 4L. pt able to use incentive spirometry & difficult able to raise one bed. SaO_2 reading 96% in room air. will monitor closely for resp. status. ———
1700	SaO_2 97% in RA for > 30 min. O_2 D/C for now. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1710	pt resting comfortably, no resp. difficulties noted. Continue monitor and encourage incentive spirometry - [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		

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1845	Received report and took over care of pt.
25 Sep 03	@ this time. Pt. resting in bed, HOB @ 45°. SPC
2010	Pt. consumed 25% of CL diet, tolerated well
	c̄ ⊖ SS N/V. b(6)-2 SPC [redacted]
2300	Pt. repositioned in bed to a more comfortable
	position b(6)-2 SPC [redacted]
0230	Pt. spoke c̄ translator @ this time, ⊖ c/o pain/discomfort
	@ this time. MSO4 from 0100 had a ⊖ effect. SPC [redacted]
26 Sep 0645	Assumed care of pt. USS. Pt resting in bed c̄ eyes
	open. Will continue to monitor. SPC [redacted] b(6)-2
0915	Got pt up to chair. Pt desated, put pt on non-rebreather
	Monitored pt for 1 hr. Put pt
26 Sep	Nutrition Consult: Pt tol CLD well. Recommend adv
1200	to FLD. If pt tol FLD well, adv to regular to meet pt's
	ENN: 2100-2450 (30-35 kcal/kg) + 91-105 g Pro/day
	(1.3-1.5 g/kg) [redacted] RD/LD b(6)-2
	Temp 102 Sats 90 ↓
26 Sept	- PT Given 4 mg morphine by anesthesia USS HR 146, RR 39 BP 120/101
1515	PT is ST 90% on 15 non-rebreather Trach 24 cm @ Teeth. 1537
	Sats 98% BVM. 2 cultures? A-line @ 1530. Triple lumen
	@ 1545. Pulse 138 BP 144/56 R 19 O2 98%

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 SEP 03 @ 1530	ANESTHESIA: Called to ICU2 for emergent intubation, pt having noted respiratory distress. SaO2 87% and falling. 200mg Propofol and 100mg SUX given, DL x 2 miller 2 Grade I view, 8.0 ETT placed 24 cm @ lip. (+) BBS, VSS and remains [redacted] SaO2 improved to 100% post intubation. [redacted] CPT, AN, CRNA b(6)-2
26 Sep 03 1500	Late entry. Called to bedside. pt having acute episodic respiratory distress. pt shaking and shivering. 100% NRB on. pt anxious, tachypnic respiratory rate 50's. SaO2 72%. Unable to raise O2. ↑ HOB to 45°. Called interpreter to bedside. Through the interpreter, pt states she is not able to breath. Coughing up thick cream color sputum x2. Lungs - course rhonchi bilaterally plus. Unhearing noted to (L) side of lung fields. (R) lower base. crackles auscultated. Anesthesia and MD's called to bedside. Dr. Mulligan and anesthesia team @ bedside. pt given 20mg IVP given @ 1440 by CPT [illegible]. pt intubated by anesthesia using 8.0 cm ETT via orally, and taped @ 24 cm to lip. Good bilateral breath sounds auscultated. Attempted A-line stick x2 ~~&~~ success. Placed A-line to (L) radial per Dr. [redacted]

STANDARD FORM 509 (REV. 6/1998) BACK
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b(6)-2 MAJ [illegible]

b(6)-2 A1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 Sep 03 2000	VS: T100' HR 116 91/59 [redacted]
26 Sep 03 2010	119 BP 95/60 R15 - Tolerating well [redacted]
2035	VS: HR115 BP 91/59 R14 T100' 98%
[redacted]	Completed Transfusion [redacted]
2040	~~Started~~ Tolerating 2nd unit PRBC (started @2030) HR114 BP 86/57 14 97% [redacted]
26 Sep 2050	HR 114 BP 86/57 T100 [redacted]
2100	T99.6 HR111 BP 97/59 98% No complications [redacted]
2115	99.6 HR115 95/60 R14 [redacted]
2130	HR 110 BP 95/88 [redacted]
2145	T99.6 HR110 BP 92/57 R14 SpO2 99% Tolerated transfusion well completed 2nd unit. [redacted]
27 Sep 03 0200	Pt comfortable. Sedated on previously mentioned drips VSS. Currently weaning FIO2 vent SIMV R12 PIO TV 800 FIO2 55% SpO2 97-99%. Cont. c̄ antibiotic therapy No changes in status will cont. to monitor [redacted]
27 Sep 03 0530	Pt c̄ stable VS. No changes in status. Receiving IVF and sedatives and paralytic. MAP 70-80's. IV's patent skin care done. Scant amt secretions. Will cont. to monitor [redacted]
0630	Assumed care of pt resting comfortably in bed sedated c̄ versed 5mg/hr + morphine 4mg/hr. Paralyzed c̄ vec c̄ 7mg/hr. See DA 4700 for initial assessment. Will continue to monitor [redacted] cathe
1000	Pt continues to rest comfortably in bed sedation remains the same. Vent settings changed to SIMV 12, TV 800, Peep 10, FIO2 40%. Will continue to monitor and obtain ABG in 30 minutes [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
~~26/9/03~~ 1845	T/c 4/u PRBC, vanc @ Bedside c̄ Neosynephrine to Bedside. b(6)-2 CPT [redacted]
26 Sep 03 1840	Assumed care of pt from previous shift. Pt currently sedated c̄ versed c 5mg/hr, MSO4 4mg/hr, Vecuronium c ~~4mg/hr~~ 2mg/hr. currently infusing c 1.2 mcg/kg/min. Receiving heparin c 1000u/hr. Intubated c̄ vent c SIMV R14 P10 TV 800 100%. Labs drawn for CBC and T+C. #8.0 24c teeth. ABG drawn and results given to Dr [redacted] 18G started on (L) FA. Vancomycin started. Midline abdominal incision c̄ steristrips No distress noted c present Will cont. to monitor — [redacted] b(6)-2
26 Sep 03 2000	Remains on above mentioned vent settings Vecuronium infusing c 7mg/hr. (B) breath sounds auscultated (R) mid and lower lobes diminished c̄ crackles to (R) side CTA on (L) lobes. Palpable pulses 2+ Cap refill 3 secs. Bowel sounds x 4 quads. Drsg to RLQ from old ~~drain~~ drain site no drainage noted. Midline incision intact c̄ steristrips. foley to BSD. c̄ dark yellow-amber urine. (R) SC triple lumen intact and patent. IVF D5 ½NS c̄ 20kcl c 125/hr. Tolerating PRBC transfusion s̄ complications H/H 7.6/24.9. (L) Rad Aline intact MAP 60-67. Will cont. to monitor status [redacted] b(6)-2
Latterly 1945	VS 100.1 HR 117 BP 88/57 started transfusion c 1940
1950	HR 117 T 100.1 BP 92/59 — b(6)-2 [redacted]

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#[redacted] EPW b(6)-4

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DATE	NOTES
26Sep03 1600	A-line pressure bag intact. A-line zeroed and calibrated. Labs drawn and sent to lab. CBC, PT/PTT, ABG, Lytes. Portable CXR done. Central line placement done per Dr. [redacted]. (R) subclavian line successful 1st attempt. all lines flushed and patent. portable CXR done for placement check. MSO4 4mg/Versed 4mg IVP given prior to Intubation. SaO2 ↑ 100% ↓ 20 minutes of intubation. CXR confirmed by MD. ordered to D/C (L) central line. Ordered to pull back 2cm.
1630	RT pulled back 2cm. shaved face for better ET securement. ABG results for 1615. pH 7.411 pCO2, 40.1. PO2 73. HCO3, 26 BE 1mm SO2 95%. Vent settings: TV 800 FIO2 100% Rate 14. peep 5. pt sedated c̄ Versed drip 50mg/50ml NS @ 6mg/hr. MSO4 50mg/50ml NS @ 7mg/hr. Vacuronium 50mg/50ml NS @ 7mg/hr. HR 147 [redacted] b(6)-2 BP 126/65 Rate 14. SaO2 95% — [redacted] HJ Am.

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DATE	NOTES
26Sep03 1645	All IVF's infusing per (R) subclavian triple lumen cath. Blood culture X2 drawn. ~~Drop~~ One per (R) subclavian, One from (L) radial A-line. D5½NS# 20KCL @125 c/hr via pump. Pt sedated, no aspiration noted [redacted]
1720	ABG Results TCO2-27mmol/L, At 37C, PH-7.449, PCO2-37.6 mmHg, PO2-53mmHg, HCO3-26mmol/L, BEecf-2mmol/L SO2-88%. SPC [redacted] 9/WMB
1835	Pt given total 1000cc NS Bolus x1 And 200cc total of 25% Albumin for low BP & PEEP ↑ From 7 to 10. SIMV RR14 TV 800 FIO2 100%. ABG @ 1800: 7.4/38/73/25/0 Pt has been on 100% FIO2 since intubation @ 1515. Pt has desatted into the high 80's c̄ 100% FIO2 - Dr Mulligan aware - when bagged pt desatted even lower. No PEEP valve on Ambu BAG. Pt c̄ MAP 59-61 since PEEP ↑ to 10: Pt has BBS, CTA, clear when suctioned via ETT. ETT #8, 22@lip taped to (R) side of mouth. Versed @ 5mg°, MSO4 4, Vec. 1.2mg-kg-min and Heparin @ 1000units/hr. No Bolus of heparin given PT/PTT ā Heparin began 15.5/27.4 sec. Next coag due ~~to~~ at 2300. No parameters given per Dr [redacted] @ this time. Report given to CPT Weston - pt supine in bed c̄ HR 120's/BP 89/56 (67)/RR 14/SpO2 96% c̄ 100% FIO2. (L) RADIAL ART intact c̄ good waveform — CPT [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
26 Sept 03 0040	Pt being moved by nurse. Pre tx HR 121, RR 32, 92% SPO2 on RA. UD Alb neb given via aerosol mask. Post tx HR 118, RR 30, SPO2 97% on RA. —— Sgt [redacted] 9/1/0
26 Sep 03 0610	Pt awakens easily. Pre tx HR 119, RR 32, SPO2 90 @ RA. UD Alb neb given. BBS CTA c̄ bases slightly diminished. Post tx HR 112, RR 30, SPO2 90. IS done —— Sgt [redacted] Pt placed back on .5L NC SPO2 92% —— Sgt [redacted]
27 Sep 03 0610	Pt intubated. Settings SIMV 12 800 50% +10, PIP 36, HR 105, SPO2 97%. No new orders written post intubation BBS coarse ⊖ wheezing. HME placed in line. Neb tx given per nurse request. Told nurse to either ask MD to resume orders or write new one or the tx will be canceled. Pt was intubated due to respiratory distress earlier in day 26 Sep 03 about 1500. Doctors states suspect P.E. Pt's ABG as of 0570 27 Sept 03 are as follows 7.43/39/137/26/2/99%. Will continue to monitor —— Sgt [redacted] 9/27
	Pt. given UD Alb & UD Atrovent via in line @ 9L p. P 95-104 RR 19-17 BBS CTA
10 Oct 03	UD Atr/Alb tx given Pre tx HR 92 RR 16 SPO2 98%
1800	Post Tx HR 100 RR 16 SPO2 99% BBS coarse Pt Secretion < 5cc watery secretions removed Sgt [redacted] 9/120
10 Oct 03	UD Alb tx via in line Pre Tx HR 120 RR 24 SPO2 94% on 40% FIO2 BS coarse Post tx HR 124 RR 18 SPO2 97% Pt Secretions removed 8cc clear secretions BS no change Sgt [redacted] 9/120

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b(6)-2
A11

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Sept 03 0615	RT note: Pt awake. Pre tx HR 103, RR 24, SPO2 95% on 3 L NC. UD Alb given via aerosol mask. Post BBS diminished. Post tx HR 105, RR 29, SPO2 99% on 3L NC. IS done with weak effort effort. Sx done. Will continue to monitor b(6)-2 Sgt [redacted]
24 Sept 1815	RT NOTE: Pre Tx HR 114 RR 25 SPO2 99% on 4L BBS Diminished UD Alb tx given Post tx HR 115 RR 30 SPO2 98% BBS NO change b(6)-2 Sgt [redacted] 91U
24 Sept 2330	Rt note: Pt awake. Pre tx HR 115, RR 31, SPO2 100% on 6L SM. BBS diminished but clear upper lobes. UD Alb neb given via aerosol mask. Post tx HR 121, RR 32, SPO2 100% on 4L NC. Pt suctioned c̄ scant amount. Pt cough ~ thick yellow. IS done with weak effort probably dued to language barrier. b(6)-2 Sg [redacted]
25 Sept 03 0615	Pt awakes easily. Pre tx HR 105, RR 24, SPO2 99 on 6L SM. UD Alb neb given via aerosol mask. BBS faint wheezing otherwise diminished. Post tx HR 105, RR 26, SPO2 98-99% on 6L. Pt on RA SPO2 94-97% will continue to monitor b(6)-2 [redacted] 91U
25 Sept 03 1823	Pt awake + alert Pre tx HR 109 RR 24 SPO2 95% on RA. BBS Diminished Post tx HR 109 RR 31 SPO2 94% on RA BBS Diminishe Lower lobes b(6)-2 Sgt [redacted] 91U

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USAPA V1.00

b(6) - 2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27Sep03 2140	HR 112 BP 132/57 RR 17 96% T101° [redacted]
2145	HR 117 145/67 RR 17 91%. Pt rec'd Tylenol suppository [redacted]
27Sep03 2150	HR 122 T102° BP 154/72 RR 16 95% [redacted]
27Sep 2220	HR 112 BP 125/46 95% T101.5 ~~RR 2~~ [redacted]
27Sep03 2300	Pt tolerating transfusion well. No distress noted. Pt c̄ bruise to lower back and (L) ~~lower~~ hip area [redacted]
27Sep 2305	Completed transfusion HR 116 T101° 144/68 Tolerated well [redacted] Will cont. to monitor [redacted]
28Sep03 0000	assumed care of pt. Nursed/MSO4/Rec'd for sedation. Heparin @ 1000u/Hr + D5½NS TKO @125. VSS. Pt supine @4hrs time. Will turn q2. CTM — CPT [redacted]
0800	pt turned to (R) side. Suctioned q1° ETT + orally. SIMV R16/500/50%/10. SaO2 ≥97%. — CPT [redacted]
1000	Pts IVABX given per schedule. Pt turned to (L) side. CTM. — CPT [redacted]
1300	NGT placed to (R) nare. CXR portable ordered to verify placement. Will attatch to LWS upon verification by MD. VSS. Ativan d/c'd. POC: Begin feeds this evening or in a.m. of Osmolite. Goal rate 100cc/hr. CTM — CPT [redacted]
1700	Pt turned q2°, Suctioned via 1° + prn via ETT and orally. Yellowish thick secretions via ETT / white thin secretions via oral cavity. VSS. Rec/Nurse/MSO4 decreased for 1-2 twitches / NTE 4 twitches. Per Dr. [redacted] NGT TO LWS → thin watery light green fluid being removed. Coag/CBC/met 8/ABG drawn @ 1700. Awaiting results. VSS — CPT [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27Sept03 1110	FIO_2 increased to 50% secondary to PO_2 being 62 on last ABG. Will repeat ABG in 30 minutes b(6)-2 [redacted]
1300	Pt c̄ increased secretions noted via ETT. Thick tracheobronchial suctioned p̄ pt's O_2 sats ↓ to 92. FIO_2 increased to 60% c̄ ABG to follow b(6)-2 [redacted]
1402	Pt c̄ temp of 101.3. Tylenol 650mg PR given per physician orders will continue to monitor b(6)-2 [redacted]
1600	Pt c̄ ↑ O_2 sat p̄ being suctioned. Will continue to monitor b(6)-2 [redacted]
~~27Sep03~~	
27Sep03 1800	Rec'd report from previous shift. On ventilator SIMV R 16 PIC TV 800 FIO_2 60%. Sedated c̄ versed @ 5mg/hr MSO4 4mg/hr and vecuronium 7mg/hr. Receiving D5½NS c̄ 20KCl @125/hr Heparin @ 1000u/hr. Pt c̄ @ rhonchi diminished breath sounds to RLL suctioning thick yellowish secretions orally and via ETT. Palpable pulses @ lt. Edema Abd round soft c̄ hypoact. bowel sounds. Midline abdominal incision intact c̄ steristrips to site. Old drain site c̄ no new drainage. Foley to BSO c̄ amber urine. USS. (R) SC triple lumen, (L) Rad Aline and 18G PIV. Will cont. to monitor-suction
27Sep03 2135 ~~2130~~ [redacted]	Pt ~~transfused~~ Started 1u PRBC H/H 8.9/28.8 Tolerating well. IVF cont. to infuse No distress b(6)-2 [redacted]

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b16 b2 A1L

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	weaned to 50% FIO2 c̄ SPO2 >93%. Ave. adt 95%. Suctioning Q1° c̄ Neb tx per order. Pt began to desat to low 90-92% c̄ 50% FIO2 - currently @ 60% FIO2 c̄ SPO2 ~94-95%. VSS @ this time. Yo ~ 100-200cc amber concentrated urine. ABG/coags/CBC/LFT sent off @ 1700. Report given to CPT weston. ——— CPT [redacted]
29Sep03 1800	Rec'd report from previous shift. VSS febrile. Sedated versed 5mg/hr, MSO4 @ 5mg/hr and vecuronium @ 4mg/hr. Pupils 1mm nonreactive jaundiced sclera. #8.0 ETT 24@ teeth. SIMV R/C P/O TV 800 60%. Lungs coarse @ suctioning thick yellowish secretions via ETT and orally. Palpable pulses @ 1+. Abd round distended c̄ absent bowel sounds. Midline incision intact c̄ steristrips to site ø drainage. NGT to (R) nare LIS. foley cath BSO c̄ amber colored urine. (R) SC triple lumen cath intact (L) Radial aline intact BG to (L) LA. Heparin infusing @ 1000u/h and D5 1/2NS c̄ 20KCl @ 125/hr. Will cont. to monitor - [redacted]
30Sep03 0100	Pt c̄ any changes in status Temp decreased 100.4 Weaned FIO2 to 50%. Pt tolerating well c̄ SpO2 96-99%. AM care done Pt noted to have yeast to groin area, rash to inner thigh area by scrotum. Will discuss c̄ physician in AM. Labs drawn K+ 2.9 Ordered KCl gtt per Dr [redacted]. Will cont. to monitor - [redacted]
0600	Pt c̄ any changes. Rec'd 1st KCl bolus c̄ complications IV lines patent. Labs drawn. No distress noted ——— [redacted]

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b(6)-2 AM

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0330	PT C̄ PEAK PRESSURE @ 47. ETT SUCTION DONE PASSING SUCTION x3 C̄ RESULTANT COPIOUS THICK WHITISH YELLOW SECRETIONS. PT PEAK PRESSURE ↓ TO 33. SpO2 MAINTAINED @ 96-97%. WILL CONTINUE TO MONITOR. [redacted]
0500	LABS SENT. CBC AND COAG [redacted]
LE 0410	BED BATH GIVEN. FOLEY CARE DONE. MOUTH CARE DONE C̄ ORAL SUCTION AND GLYCERINE SWABS. DRSG TO RUQ CHANGED PREVIOUS DRSG C̄ NIGHT SIZE SEROUS DRAINAGE. Ø S/S INFECTION. BED LINEN CHANGED AND PT REPOSITIONED [redacted]
29/9/03 1500	[redacted] assumed care of pt @ 0600. USS, Intubated sedated c̄ SpO2 -97%. Simv R 16/800/50%/5/97% SpO2. Uneventful day until 1100 when pt went to CT Scan for chest/abd/pelvic contrast via orally + IV. Pt never received CT Scan d/t she could not maintain her SpO2 c̄ FiO2 @ 100%, P↑ to 10 from 5. aggressive suctioning by RN & RT. CXR done - pulled ETT back 2 cm - Raised pt to 20% angle then SpO2 ↑ 91-94%. Pt returned to ICU c̄ put back on vent and was able to maintain SpO2 -100% c̄ 100% FiO2. Pt then

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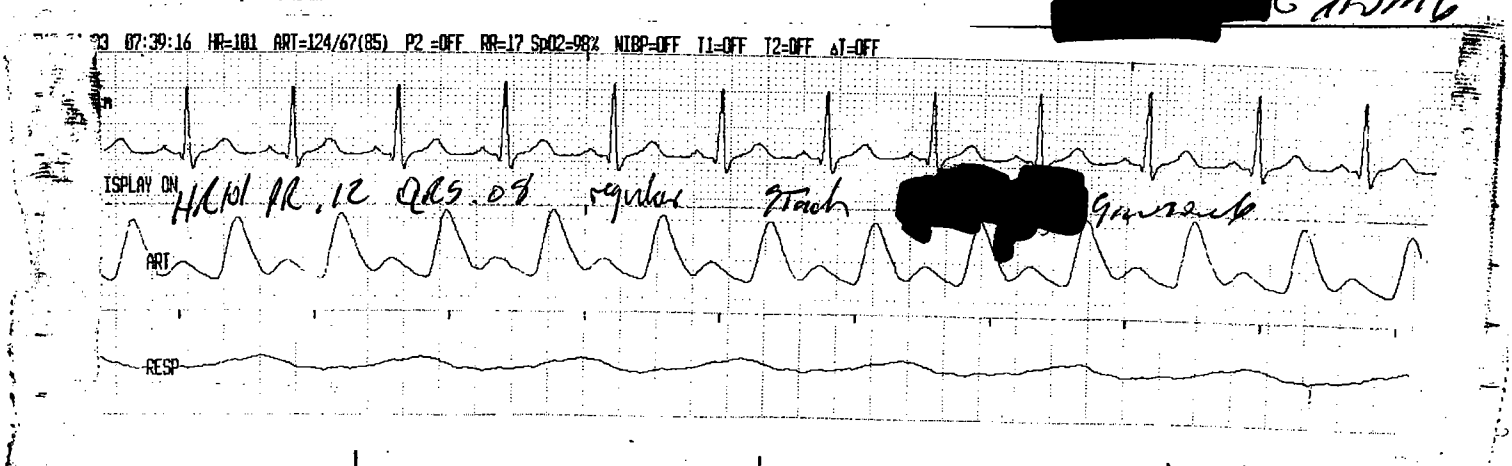
MEDICAL RECORD	PROGRESS NOTES b(6)-2

DATE	NOTES
30 Sep 03 1800	Rec'd report from previous shift. SpO2 90-92%. Suctioned orally and via ETT c̄ thick yellowish secretions. Then increased to 95%. Meds currently infusing versed 5mg/hr MSO4 5mg/hr and vecuronium 4mg/hr. D5 1/2 NS c̄ 20KCl @125/hr. Heparin 1000u/hr. Cont. c̄ antibiotic therapy. NGT to LIS to (R) nare. Foley c̄ amber urine. Will cont. to monitor status — [redacted]
1 Oct 03 0400	Pt febrile 100. Measures taken through night to decrease temp. AM care done. No changes in status. (R) SC triple lumen and (L) FA PIV intact and patent. (L) Rad Aline intact. No distress noted. Copious amt secretions suctioned. Will cont. to monitor — [redacted]
1-Oct-03 0630	VS 111/60-99°-104-17-98% SpO2 on SIMV Rate 16, PEEP 5, TV 800 FiO2 40%, #8 ETT, 24 cm @ teeth, Assessment on Medical FSG OP 375 dated 1-Oct-03, received report. [redacted] G Shim



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STANDARD FORM 509 (REV. 6/1998)
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b(6)-4 b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
1-10-03 1400	VSS. Pt transported to and from CT @ 1000 hrs. Pt tolerated transport c difficulty. Pt's ABG Δ'd 2° to O_2 ~~Acid Fast Acetobacter~~ Ø cultures noted so new ABG. Will cont to monitor — [redacted] SSG Gurnee
1-10-03 1600	VSS 96-98-108/56-16-96% SpO_2 on [redacted] SIMV 16, PEEP 5 TV 800, FiO_2 40%. Pt suctioned and produced dark yellowish frothy secretions from ETT. Pt's lab results from CTS reviewed. Pt ⊕ for Acinetobacter. Will continue to monitor — [redacted] SSG Gurnee
1 Oct 03 1800	Rec'd report from previous shift VSS. Sedated versed 8mg/hr, MSO4 5mg/hr, vecuronium 4mg/hr. vent SIMV R16 TV800 P5, FiO_2 40%. Thick whitish secretions. Pupils sluggish but reactive 2mm. Equal chest expansion. Coarse BBS. Palpable pulses ⊘ edema. (R) SC triple lumen (L) Radial Aline PIV x1. Abd round soft c̄ absent bowel sounds NGT ⊕ (R) nare LIS. Midline Abd. incision intact c̄ steristrips to site. Foley to BSD c̄ amber urine. Currently infusing Heparin 1000 u/hr D5 ½ NS c̄ 20 KCl @ 125/hr Will cont. to monitor — [redacted]
20 Oct 03 0000	Pt c̄ any changes in status VS remain stable. Dobhoff tube placed to (L) nare per Dr Mullyan placement confirmed via XR clamped @ present. IVF cont. to infuse. Bruise remains to (L) back/hip area. No distress noted — [redacted]
20 Oct 03 0425	20G IV placed to (L) FA AM care done. No changes in status Will cont to monitor — [redacted]
2-Oct-03 0623	VSS, Assumed care of Pt, Pt sedated and paralyzed c̄ MSO4 IV gtt, versed gtt, and Vecuronium gtt. Vents - #6 ETT, 24 cm @ lip. SIMV 16 Peep 5, TV 800, FiO_2 40%. Assment on [redacted] dated 2-Oct-03. Will monitor — (b)(2)-2
	[redacted]

S[redacted]09 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2 Oct-03 1000	Pt open eyes, Pt responded and pt nodded head. Vent SIMV, 16 TV 800, PEEP 5, FiO2 40%, VSS, UOP > 100 cc/hr amber clear Q2° turning. Pt dressing intact. Lung sounds coarse B. Pt suctioned → produced thick clear slight blood tinged sputum.
2-Oct-03 1200	Pt started on Tube feedings per ~~Dopt~~ Dophoff tube. Placement checked c̄ 20 cc air. Feeding was started but IV pump indicated back flow from tube. I attempted to draw back on tube c̄ a syringe c̄ no success. Will notify MD. Pt VSS. NG Tube clamped. [redacted] ESC 9/WM30026
2-Oct-03 1600	Dr [redacted] states try Coca cola to break up clot in Dophoff. 1st attempt no success.
02 Oct 03 1800	received report from outgoing shift. Initial assessment on DA 4700. VSS NAD attempted to unclogge dobhoff without sucess c̄ Coca cola per MD orders unsuccessful. MD notified [redacted] 9/WM
02 Oct 03 1930	- Dobhoff (L) nare difficult to remove Dr [redacted] notified - Dr [redacted] Dr [redacted] MD CXR - PT VSS NAD. SGT W[redacted] 9/WM
2000	CXR complete - Dr [redacted] stated X ray

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

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b(6) - 2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	unremarkable - Dobhoff advanced then removed 3 difficulty VSS NAD. SGT [redacted] 91WM0
02Oct03 2230	Dobhoff placed (L) nare tolerated well NAD NG tube D/ced SGT [redacted]
~~03~~ Oct03 0200	- pt bath provided foley care provided linen Δ'ed - bite blocked Δ'ed by PT mouth care provided tolerated well pt positioned (R) side posterior aspect skin integrity intact noted medial thighs by groin skin erythemic & whitish top. (-) odor. will inform MD in am VSS NAD SGT [redacted] 91WM0
Late entry 2230	p Dobhoff placement - KUB - Dr [redacted] reviewed X-ray. Osmolyte GN @ 10cc/hr. ∅ residual ✓ per MD order will cont to monitor SGT [redacted] 91WM0
2300	Residual from Dobhoff ↓ 5cc Osmolyte 15 cc green bile SGT [redacted]
03Oct 2400	Residual from Dobhoff 10cc ~~bilat~~ bile (green) SGT [redacted]
0100 -	residual from Dobhoff 5cc green bile SGT [redacted]
0200	- Residual from Dobhoff 5cc green bile SGT [redacted]
0300	Residual from Dobhoff 10cc green bile SGT [redacted] 91WM0

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MEDICAL RECORD	PROGRESS NOTES b(6)-2 A11
DATE	NOTES
03Oct03	dobhoff residual 5cc SGT [redacted]
0500	
0600	dobhoff residual 10cc green bile 1/3 was Osmolyte SGT [redacted]
3-Oct-03 0625	VSS, PT responsive to touch, Assessment on [redacted] OR 375 dated 3-Oct-03. Vent settings SIMV, 16, TV 800, FiO2 40%. ETT 29cm @ teeth, will monitor [redacted]
3-Oct-03 0900	Vent Rate Δ'd to 8 BPM PER Dr. [redacted]. PT has additional breaths against the vent. Will check ABG in 30 minutes. [redacted]
3-Oct-03 1000	PT's ABG came back. Values noted on flowsheet [redacted]
1025	Dr. [redacted] informed of pt's ABG results. He was satisfied c̄ PaO2 78%. Pt's RR ↓ to 4 BPM and PCO2 @ 45%. ABG to be done @ 1100. -CR [redacted]
3-Oct-03 1200	PT extubated by Dr. [redacted] VS 122/66-99 T 97-26-100% SpO2 via venturi mask. PT alert, and cough and deep breath, coughed clear thick sputum ∓ extubation, lungs coarse (B), equal rise and fall of chest ∅ accessory muscle use. [redacted]
3-Oct-03 1400	VS 122/81-99 T-97-28-96% SpO2 on RA, PT AOx3, on [illegible], IS in use Q1+ Lungs, Coarse BS, ↓ RLL, ∅ [redacted] muscle use. [redacted]

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b(6)-4

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
30 Sep 03 1540	Pt sitting up in bed c̄ assistance. NGB ⊼ gain, wheezes heard @ side lung. Chest PT performed c̄ PT pt coughing up very little clear to yellow mucous. Pt SpO2 ↓ 88 and he was placed on NRB @ 15 LPM producing SpO2 of 94%. After 20 minutes pt was 1520, pt was placed in bed. He was Δ'd to a venturi mask at 50% O2. Will monitor. b(6)-2 [redacted]
03 OCT 03 2120	Assumed care of pt @ 1800. VSS, temp 99°, now 99.4° A&O. lung sounds clear bilaterally apex to base, c̄ diminished bases bilaterally. O2 Sat 94-97% on venturi mask @ 50% RR 29-40's. Ø use of accessory muscles noted. Encouraged to use IS. Radial & Pedal pulses strong & equal to palpation bilaterally. Cap Refill < 3 sec to all extremities. PERRL, 4mm. Mucous membranes moist. Pt allowed sips of water. Pt has (R) triple lumen, CDI, Ø redness or infiltration noted. (R) MEF (L) Radial A line, Ø redness MEF or infiltration noted. Pt has Steri Strips to midline abdomen, CDI, Ø drainage noted. Pt has dressing to RLQ, Ø drainage noted. BS active x4 quadrants, Ø tender, Ø distended, soft. Pt has foley to gravity draining light amber colored urine. Pt has complete ROM to all extremities. BLE stiff & slightly painful c̄ movement. Will continue to monitor for Δ's. b(6)-2 SPC [redacted] Womle
04 OCT 03 0036	Continues on IV abx.
0500 MEF	Pt lab results showed PTs to be 82%. MD notified. No action taken per MD assessment. Will continue to monitor. – SPC Fowler, Megan 9 Wom
LE 0200	CBC, PT/PTT, & Chem 8 sent to lab. Will continue to monitor & report results to MD. b(6)-2 SPC [redacted]
	Pt placed on 4L O2, humidified by RT. Δ'd to 5L O2 via NC (0030) due to O2 Sat of 91%. Will continue to monitor. – SPC [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04Oct03	switch to non rebreather 15l SaO2 ↑ 92% - cont 94%. pt sitted up c feet over edge of bed - chest pt to posterior - (+) pro sputum - noted BM liquid strong smell ABD soft NT (-) DTN BS active X4. Skin strip medline abd intact (-) drg. noted a line (L) wrist removed, (R) SC line Rm D52NS @ 20K @ 125 hr/ will cont to monitor SKP
04Oct03 0440	RT note: ABG FiO2 59% VM: 7.48/39.9/114/24/1/99% - Sgt [redacted]
04Oct03 1920 late entry	- Desat 78% c NR 15l - positioned in bed. R-56 - bagged w/ 15l O2 color pale - (+) diaphoresis denies CP. incident occured while pt standing c assist for linen Δ. RT called. HOB ↑ 90% - SaO2 95% 15l O2 NR after bagging color improved. ABG - 7.472 pCO2 33.5 pO2 51 BE 1 HCO3 24 ScO2 89 physician notified Dr [redacted] will monitor closely SKP [redacted] 9MM b(6)-2
04Oct03 2300	- VSS IS - nebs per MD order ↑ 2° chest pt c assist from RT. SaO2 96-98% 15l venturi. c cont to monitor SKP
0200	- VSS SaO2 99% 15l venturi Albuterol + chest pt c IS q 2°. pt doing well NAD. each chest pt (+) production is amt yellow tinged mucus - will cont to monitor SKP [redacted] 9MM

b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(4)-2 AU

1205 Accumed care of pt [redacted] report given. Alert. PERRL @2mm. Lung sounds clear to bed bil. Diminished L/lobes bil. = rise & fall of chest bil. (+) bowel sounds x4 in all quads. Midline ABD incision steri-strips CDI. LUQ small wound noted. No active bleeding or drainage noted. Skin warm to touch. (+) radial & pedal pulses bil. HR 10[illegible] ST. Will cont. to monitor [redacted]

1240 Sit pt up @ bedside chair. SPO2 ↓ 89 O2 ↑ to 6 L/min NC. Will cont to monitor. SPO2 ↑ to 97%. Will cont to monitor [redacted]

1330 A line zeroed. A line (L) wrist. (+) ACW 5 [illegible] or infiltration noted. Will cont. to monitor [redacted]

1530 SPO2 ↓ 88%. Applied Face Mask: SPO2 @ 92%. Will cont. to monitor [redacted]

1600 New Order recieved from Dr. [redacted] Urist pt [redacted]

04 Oct 03 1800 received report from outgoing shift pt Alert SaO2 88 ↓ A face mask 10 L. positioned pt upright 75° TS Aggressively. R 40 even shallow (+) use abd muscles. (+) chest pt. productive yellowish thick sputum LS ↓ la (+) Rhonchi

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

REGISTER NO. | WARD NO.

#[redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
#[redacted]			

DATE	NOTES
4 Oct 03 0156	RT note: Pt awake. Pre tx HR 99, RR 28, SPO2 93% on 50% venti mask but @ 5 LPM instead of 10. BBS CTA upper + diminished @ bases. Post UD Alb & Atro given via Venturi mask. Post tx HR 97, RR 30, SPO2 96% on 6L aerosol mask. Will placed pt on 4L NC c bubble humidifier. IS done with good effort. — Sgt [redacted] 91V2Y
4 Oct 03 0540	Pt awake. Pre tx HR 97, RR 30, SPO2 94% on 5L NC. BBS CTA upper + diminished lower. UD Alb given. Post tx HR 104, RR 38, SPO2 95% on 6L aerosol. — Sgt [redacted]
4 Oct 1732	Pt awake Pre tx HR 103 RR 25 SPO2 93% 5L simple mask BBS CTA Lower lobes diminished UD Alb/Atro given on 6L Post tx HR 102 RR 26 SPO2 95% BBS CTa diminished RLL Pt able to cough throughout tx — Sgt [redacted] 91V2Y
2000	Pt pt Dsat 89% non rebreather placed on pt. placed on 10L ABG PH 7.472 PCO2 33.5 PO2 51 BE 1 HCO3 24 SaO2 89%. episode happened after LPN was moving pt around having him stand while changing sheets. Sgt [redacted] 91V2Y
2136	Pt awake HR 114 RR 33 SPO2 92% 15L Non rebreather BBS upper lobe CTA lower lobes Diminished UD Alb tx given Pt able to cough During tx Post tx HR 110 RR 47 SPO2 92% Pt very labored Pt still having difficulty maintaining Sat Doctor informed —
2218 BG	PH 7.565 PCO2 23.5 PO2 51 BE 4 HCO3 26 SO2 91%
5 Oct 03 0510	Pre tx HR 102, RR 33, SPO2 96% on 15L NRB. UD Alb & Atro given BBS CTA c slight diminish at bases. Post tx HR 102, RR 40, SPO2 94% on 5L aerosol mask. Pt SPO2 95-96% 50% venti mask. — S[redacted] 91V2Y

P[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2 A11
23 Sept 03	UD Alb tx given Pre tx HR 101 RR 25 SPO2 96% on 2L NC
1741	BBS Diminished
24 Sept 03 * 0813	Pre tx HR 111, RR-20, SPO2 96% on 6 L SM. UD Alb Neb given, BBS coarse + diminished. Post tx HR 118, RR 30, SPO2 94%. Nasal pharyngeal sx performed c̄ good cough reflex & Pt coughed up 3cc thick yellow mucous. Sx ≈ 3cc clear fluid. Pt perform IS weakly. Will continue to monitor Sg[redacted]
1 Oct 03	Pt. given UD Alb via inline @ 9L pr P111-114 RR 29-16 O2SAT 95%-98% Pt. sx for small amount of yellow sputum. SGT [redacted]
2 OCT 03	UD Alb/Atro given HR 102 RR 16 SPO2 98% BBS coarse
1821	pt suctioned small amount of secretion Post tx HR 103 RR 16 SPO2 98% BBS coarse
2 OCT	UD Alb tx via inline @ 6LPM HR 105 RR 16 SPO2 96% BS coarse
2130	pt suctioned
3 Oct 03 0145	UD Alb/Atro given. HR 103, RR 23, SPO2 97% BS coarse but upper CTA. Sx minimal amount. Sg[redacted] nurse
	UD Alb/Atro Pre tx HR 100 RR 28 SPO2 94% BS Diminished Post tx HR 101 RR 23 SPO2 98% BS NO change pt instructed on IS Sgt [redacted] 71U25Y

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Pt [redacted] b(6)-1		

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MEDICAL RECORD	PROGRESS NOTES b(6)-2 A11
DATE	NOTES
5-OCT-03 0630	Assumed care of pt. PT AOX3, can follow instructions. Moves and sensations x 4 extremities, pupils 3mm sluggish OU, Nebs: mask c 8LPM O2 @ 40%. Coarse (B) lung sounds auth, equal rise on bell of chest. PT receiving NEB Tx and Chest PT from Resp. Tech. Bilateral Tach c entopy, rate 100-110, + 2 pulses throughout. (A) subclavian triple lumen, medial port clogged, (R) radial A-line, (L) AC saline lock patent, sites CLOTT, ABD round, midline staples clott, BS x 4 quadrants, NT, small BM noted. Foley to gravity drainage 2100 cc clear amber urine. [redacted] SG Tavarez
5-OCT-03 0800	PT ET OOB to chair, SPO2 ↓, pt. placed on NRB mask @ 15 LPM SpO2 93%. Chest PT performed and pt coughed thick yellow secretions. Will monitor. [redacted] SG Tavarez
5-OCT-03 1200	2 PIV's started on pt. 18G (L) AC - patent / site clott. 18g (R) forearm - patent site clotted, Anesthesia Dr. [redacted] to remove pt's central line. [redacted] SG
1815	Pt. seated in bed c HOB @ 45°, NC @ 6LPM, SpO2 100%. VSS. 0 % pain / discomfort @ this time. [redacted] SPC
1930	Pupils (=) @ 2mm, PERRLA, pt. does not speak English, is able to follow simple commands + gestures. SR in ↑90's, 0 ectopy, (+) UD, (+) 2 pulses throughout. 18G to (A) FA

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	b(6)-2 A11
1930 (cont)	has D5½NS ĉ 20K @ 125 cc/h. 18G to (R) AC hep Heparin @ 20 cc/h. (L) radial A-line zeroed + flushed @ this time. NC @ 6LPM, SaO2 99%. (A)BS x4, normoactive, last BM yesterday evening. ABD soft, round non-tender. Midline ABD incision ĉ steri-strips, CDT. 2x2 to (L) subclavian, CDT. Foley to gravity drain. QS, dark yellow, clear urine. RT giving neb tx's + doing chest PT q4O ——— SPC [redacted]
2005	Lungs diminished in bases (B), wheezing heard (B), (+) rise + fall of the chest. (+) cough ĉ thick, clear secretions. ——— SPC [redacted]
2115	Pt. ↑ OOB ĉ assistance and to bedside chair. pt. appeared to have had a small BM @ an earlier time, cleaned up. Non-rebreather mask applied prior to pts. movement. SaO2 remained above 88% during movement. Returned to 92-94% while seated in the chair. Plan to leave pt. in chair until 2200. Will continue to monitor. ——— SPC [redacted]
2210	Pt. returned to bed ĉ (+) difficulty. SaO2 remained above 86%, when pt was settled back in bed, NC applied @ 6LPM ĉ SaO2 of 94-97%. ——— [redacted]
0010	Pt. c/o NC causing discomfort to his ears, 2x2's applied between tubing + ears, pt. gave a thumbs up for improvement. ——— [redacted]

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b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	RT note : Pre tx HR 95, RR 30, SPO2 95% on 4L NC. UD Alb + Atro given via ~~[illegible]~~ aerosol mask. Post tx HR-95, RR 36, SPO2 92% on 4L NC. Pt refuse CPT. Pt verbal ~ language barrier; can not understand pt. Will continue to monitor b(6)-2 Sgt [redacted] 91V20
05 OCT 03 1326	Pt awake & sitting up HR 97 RR 30 SpO2 95% 4L NC BBS CTA UD Alb tx given HR 101 RR 29 SpO2 95% BBS No change Sgt [redacted] 91V20
5 OCT 1743	Pt awake HR 92 RR 22 SpO2 99% on 6L NC BBS CTA UD Alb/Atro nebs given Post tx BBS CTA HR 90 RR 32 SpO2 98% 6L NC Sgt [redacted] 91V20
5 OCT 03 2240	Pt awake Pre Tx HR 97 RR 18 SpO2 94% 6L NC BBS Clear b(6)-2 UD Alb tx given Post tx HR 97 SpO2 98% BBS clear Sgt [redacted] 91V20
6 Oct 03 0200	Pre tx HR 91, RR 25, SPO2 97% on 4L NC. BBS CTA. UD Alb & Atro given via aerosol mask. Post tx HR 93, RR 30, SPO2 97 on 4L NC Sgt [redacted] b(6)-2
6 Oct 03 0615	Pre tx HR 99, RR 29, SPO2 95 on 4L NC, UD Alb neb given Pt cough up thick mucous & green. Post tx HR 97, RR 35, SPO2 96 on 4L NC Sgt [redacted] 91V20 b(6)-2

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[redacted] b(2)-2

b(e)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
06OCT03	Continued:
2137	noted. O_2 Sat 96-99% on 1L O_2 via NC. Will wean as tolerated. Pt continues on Q4° neb tx c̄ Chest PT, tolerating well. RR↑20's HR 80-90's, RRR. S_1+S_2 audible. Cap Refill <3sec to all extremities. Radial+Pedal pulses strong + equal to palpation bilaterally. Pt has 18G IV to (R) forearm infusing D5½NS c̄ 20mEq KCL @ 125cc/hr. Pt has (L) radial A-line, CDI; Ø signs of redness or infiltration to either site. BS active x4 Quadrants. Non-soft, Non-tender, Non-distended. Pt has ~~sutures~~ MEF steri-strips to midline abdomen, CDI, + open to air. Pt has foley to gravity draining clear yellow urine >30cc/hr. Complete ROM to all extremities. OOBTC c̄ assistance due to stiffness. Pt has productive cough. Will continue to monitor for Δ's. ——— SPC [redacted] 91WM6
2200	Pt O_2 ↓ to 0.5L via NC. O_2 Sat 97%. Will continue to wean as tol. — SPC Fuller Mega 91WM6
2220	Pt OOBTC c̄ minimal assistance. Pt remains on 0.5L O_2 via NC. O_2 Sat ↓ to 90-93% while moving to chair. Pt taking very quick, shallow breaths. Encouraged to take deep breaths + use IS. O_2 Sat ↑ to 95%. Will continue to monitor for Δ's. ——— SPC [redacted] 91WM6
2317	Pt coughing up a large amt of yellow/green sputum. O_2 Sat ↓ 88%, O_2 ↑ to 2L, Sats 90%, ↑ 4L O_2 Sat 93-95%. Pt continuing to take short shallow breathing. Explained to pt need to take deep breaths via interpreter c̄ no effect. Pt O_2 Sat ↑ to 96% + stable when pt not coughing a lot or actively thinking about breathing. Will return to bed @ 0001 + continue to wean O_2. Will continue to monitor for Δ's. ——— SPC [redacted] 91WM6
07OCT 2400	assumed care received report from outgoing nurse. pt OOB x1 hr. tolerated well. VSS NAD A+OX3 color good SpO2 @ 98% @ .5l NC. will cont to monitor IS encouraged. SPC [redacted] 91WM6

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6 OCT 03 0530	Pt. bumped down to O_2 @ 4LPM via NC. Will monitor effects. SpO_2 currently 96% —— SPC [redacted]
6 OCT 03 0630	Assumed care of pt. PO in bed & Ax3, NAD, HOB 40° VS 144/78 (BNV), 98 (AX), 107, 12, 94% SpO_2 on 4LPM NC. (R) coarse lung sounds more ↓ on (R) base, ∅ productive cough, equal rise and fall of chest, ST rate 100-110, + 2 pulses throughout, S_1 S_2 present, (C) AC saline lock - site CLIE patent, (C) forearm saline lock CLIE, patent, AND cord, soft, ND, NT, in place incision intact, BS x 4 quadrants, foley to gravity drainage clear amber urine, >100cc/hr, [redacted]
6-OCT-03 0730	PT ate 30% of breakfast, [redacted]
6 OCT-03 0900	PO ↑ OOB to chair, Maintains SpO_2 93% on 4L O_2 via NC, Positive cough produces thick yellow secretions. Foley to gravity drains clear yellow urine, Will monitor [redacted]
6-OCT-03 1600	PO ↑ OOB to chair, Sats @ 93% on 4L via NC, PO coughs thick clear yellow mucus. IS in use. Lungs (R) base still ↓ compared to (L) base. PO Ax3, ∅ distress. [redacted]
06 OCT 03 2137	Assumed care of pt @ 1800. VSS, afebrile. Alert + Oriented. PERRL, 3mm. Mucous membranes moist. Tolerating small amts of regular diet. Lung sounds clear bilateral c̄ diminished bases c̄ R>L. RR equal + unlabored. No use of accessory muscles →

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			b(6)-2 A11

DATE	NOTES
7 Oct 03	O2 off. SPO2 @ 97%. CT PT done. IS used approx @ 10 X 5 c
1000	2nd ball raised & 3rd raised @ X5. Lung sounds CTA bil BS
	(+) in all 4 quads. Midline ABD incision c̄ steri-strip cov. Aline
	DSB (D) Pulse area c̄ DI. IV 18G (D) AC & (R) FA WNL. SPO2 @ 96%
	↓ O2 turned off. Will cont. to monitor — S[redacted]
1100	IS used approx. 15 X 5 c 2nd ball raised c̄ 3rd ball
	raised @ X5. SPO2 95%. R30. Will cont. to monitor —
	S[redacted]
1200	Chest PT done. IS used approx 15 X 5 c̄ 2nd ball raised
	& @ X5 3rd ball raised. SPO2 @ 96%. R21. Will cont to
	monitor S[redacted]
1300	IS used approx 15 X 5 c̄ 2nd ball raised & @ X5 3rd
	ball raised. SPO2 @ 96%. Will cont. to monitor S[redacted]
1400	Lung sounds CTA bil. BS (+) in all 4 quads. SPO2 @ 98%.
	Pt assisted ↑ to chair. SPO2 @ 98%. VSS. IV 18G (R) FA D5 NS
	@ 125 cc/hr via (R) FA 18G patent & SS/S of infection. 18G (L)
	AC SS/S of infection. Flushes well. Chest PT done. IS used
	@ 12 X 5 c̄ 2nd ball raised & 3rd raised @ X5. Will cont.
	to monitor S[redacted]
1500	IS used approx 12 X 5 c̄ 2nd ball raised & 3rd raised
	@ X5. SPO2 @ 97%. Will cont. to monitor — S[redacted]
1600	Chest PT done. IS used approx 12-15 X 5 c̄ 2nd ball raised
	& 3rd raised @ X5. SPO2 @ 97%. Will cont. to monitor S[redacted]
	Pt assisted back to bed — S[redacted]
1705	Report given to Spc [redacted] — S[redacted]
1730	Transferred pt to ICW 2 per litter. — S[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
06 Oct 03	2430 - pt back in bed HOB ↑ position on back ROM c̄ assist NAD VSS b(6)-2 will cont to monitor. SS [redacted] RN
0600	Accumed care of pt p night shift. Report given by SS [redacted]
10 Oct 03	CV. See assessment sheet. Will cont. to monitor [redacted]
0630	Pt assisted to chair. Chest PT done. IS used approx @ 10 X'S c̄ 2nd ball raised & @ X'S 3rd ball raised. Will cont. to monitor b(6)-2 SS [redacted]
0715	IS used approx. @ 10 X'S c̄ 2nd ball raised & [redacted] X'S 3rd ball raised. Pt sitting up in chair. Will cont. to monitor SPO2 @ 97%. R 33. b(6)-2 [redacted]
0820	CT PT done. IS used approx @ 10 X'S c̄ 2nd ball raised & 3rd raised @ X'S. Will cont. to monitor. SPO2 @ 96% R 36. b(6)-2 SS [redacted]
0850	Assisted pt back to bed. SS [redacted]
0910	A line D/C'd. Bulb intact. Pressure applied for 5 min. Applied 4x4's & secured c̄ tape. Will cont. to monitor. O2 off. SPO2 @ 96% before O2 turned off. SPO2 @ 90%. Will cont. to monitor b(6)-2 SS [redacted]
0935	SPO2 + 90%. O2 @ .5 L/min per NC. Reapplied. SPO2 97%. Will cont. to monitor. [redacted]

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

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b(6)-4

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
8 Oct 03 0600	Pre tx HR 80, SPO2 93% on RA. UD alb neb given. Pt cough throughout tx. BBS CTA. Post tx RR 20-26, SPO2 96, HR 92 IS done ——— Sgt [redacted] 9W20 (+) b(6)-2
9 Oct 03 0020	Pre tx HR 96, RR 20, SPO2 96% on RA. UD Alb neb given. BBS CTA ——. Post tx HR 92, RR 28, SPO2 96%. —Sgt [redacted]
9 Oct 03 0515	Pre tx HR 90, RR 22, SPO2 93% on RA UD Alb neb given. BBS slight coarse clears c̄ cough. Post tx HR 94, RR 30, SPO2 93-97% ——— Sgt [redacted] 9W0 b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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[redacted] b(2)-2

b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6OCT03 1747	Pt awake Pre tx hr 91 RR 24 SpO2 98% BBS CTA UD Alb tx given pt cough throughout tx HR 96 RR 22 SpO2 98% b(6)-2 Sgt [redacted] 91W20
6oct 2134	Pt awake + alert Pre tx HR 94 RR 28 SpO2 97% on 1 LNC BBS CTA Diminished CPT [redacted] pt able to cough During tx UD Alb/Atro given Post tx hr 93 SpO2 97% on 1 L NC RR 13 BBS CTA b(6)-2 Sgt [redacted] 91W20
7 oct 0200	Pt awake. Pre tx HR 92, RR 22, SPO2 96 on 0.5 L NC. BBS CTA. UD Alb & Atro given. Post tx HR 98 RR 30 SPO2 96 on 0.5 L NC. b(6)-2 Sgt [redacted] 91W20
7 Oct 03 0600	Pt awake. Pre tx HR 98, RR 20, SPO2 95 on 0.5 L NC. BBS CTA. UD Alb given via HHN c̄ mouthpiece. Pt deep breaths every 4th-5th breaths. Post HR 92, RR 28, SPO2 96% on 0.5 L NC. (+) cough up thick secretions. (+) IS b(6)-2 Sgt [redacted] 91W20
7OCT 03 1820	Pt awake Pre tx HR 92 RR 20 SpO2 94% on RA BBS CTA b(6)-2 UD Alb tx given Pt coughed throughout tx. Post tx HR 96 RR 22 SpO2 94% BBS no change Sgt [redacted] 91W20
8oct03 0020	Pre tx HR 90, RR 22, SPO2 95% on RA. BBS coarse but CTA c̄ cough. UD Alb tx given Post tx HR 93 RR 26 SpO2 94%. Sgt [redacted] 91W20 b(6)-2

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b(6)-4

Pt [redacted] ICW 2

[redacted]

Alb Q6 X 48hrs

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
090ct03 0850	VSS Alert & Oriented c/o lower abd pain and c/o not able to void. Lower abd distended. Dribbly urine from penis upon standing. Foley cath inserted 1300 cc of tea colored urine obtain Foley left in place. Lungs with scattered ronchi in upper lobes. Diminished lung sounds to lower lobes. Assisted pt OOB to chair and instructed on proper use of Incentive Spirometer. Used properly @ 900cc/sec. Has non productive cough. Midline abd. incision with edge well approximated and steri strips intact. Peripheral pulses +2. Will continue care as planned — [redacted] 2LTB
90ct03 1944	VSS. AO. Encouraged to use IS q1° for 10 times. Underbed LS course in RLL and clear in other regions. Abdominal wound CDI and [redacted] Resting comfortably in bed. — [redacted]
10oct03	(1050) Assumed care of pt @ 0600 w/ report from night shift. Pt alert, speaking Arabic VSS. Ø c/o pain. Lung sounds ↓ in lower lobes. Ø SOB or resp. distress noted. Pt amb in hallway ⅀ assist. Tol. well. Foley draining quantity sufficient clear yellow urine. IVF infusing into IV in Ⓡ forearm ⅀ difficulty. Ø sign infection/infiltration. Steri strips to midline abd incision CDI. Tol. small amount of reg. diet. ∅ point restraints in

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
08OCT03	(1635) Pt tx to ward from ICW2 in stable cond via WC. Lungs CTA(B). Decreased breath sounds in (B) ↓ lobes. Ø SOB or resp. distress noted. IVF infusing via dial-a-flow into IV in (R) ac ~~5~~ S/Sx infection/infiltration. SL in (L) ac d/cd d/t infiltration. - catheter intact. Voiding ~~5~~ difficulty. Tol po well. 2-point restraints in place ~~5~~ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]
8Oct03	1845 = VSS, O2 sats @ 96% RA post-albuterol tx. Lung sounds course & diminished (B) ↓ lobes pre-tx, sound more clear (B) ↓ lobes post-tx, reinforced IS 5x/hr while awake - pt. does IS exercises ~~5~~ difficulty. Steri strips to midline abdominal wound - healing - CDI. UOP adequate via urinal CBS. Assist OOB to ambulate in hall x 2 restraints while in bed (-) skin breakdown noted, continue to monitor for acute Δ's b(6)-2 [redacted]
~~8Oct03 @ 2300 = IV NES~~	
8Oct03 @ 2300 =	IV restarted to (L) FA, D/c'd IV to (R) FA intact. b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			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. ICWH

[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)
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FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

14 Oct 03 @ 0345 - pt. found c̄ IV pulled out & IVF's leaking on floor, instructed pt (via translator) to not pull out IV's, IV restarted to (L) hand running D5NS c̄ 20meq KCl, x2 arm restraints in place, x2 curley wrapped to wrists tied to sides of bed to prevent pulling at lines ⊖ skin breakdown, ⊖ circulatory compromise — [redacted]

14 oct 03 - 0700 - Assumed care of pt. A+O x 3. VSS. PIV infusing D5NS @ 125 cc/hr (R) hand. patent site CDI. Abdominal incision open to air secured c̄ steri strips healing well. ⊘ s/s of infection. Decub to sacrum duoderm applied. Q2h position change encouraged pt. favors supine position rolled covers to support side position. Foley to gravity. Amber urine. Q8 Encouraged PO fluid. Will cont to monitor — [redacted] RN

14 Oct 03 VSS. AO. Reinforced to pt. to discontinue pulling out IVs. Pt. IVPB by himself and pt. understood & complied. c/o pain @ this time. Abdominal incision CDI c̄ steri strips @ base intact. ⊘ s/s infection. LSCTAB. BS (+) x 4. Voiding light amber urine quantity sufficient (+) pulses. [redacted] RN

15 Oct 03 @ 0700 - Assumed care of pt. AM care given ambulated to shower c̄ difficulty. c/o SOB while in shower O2 sat 96% RA. Encouraged deep breathing lungs clear non productive cough. Abdominal incision healed well ⊘ s/s of infection remains afebrile. Breakdown to sacral/buttocks area open to air pt positioned on stomach to prevent further breakdown Q2° position change. PIV (R) hand intact D5NS c̄ 20meq KCl @ 125 cc/hr ⊘ c/o pain or discomfort @ this time. Will cont to monitor — [redacted] RN

(1245) I concur c̄ above assessment. — [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK

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b(6)-2

A11

b(6)-2 A11

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

13 Oct 03 0933 Received pt resting in bed, VSS, tol PO poor appetite for breakfast this am. Amb in hallway w/ walker, and to BR. Am care provided, LSSA, duoderm placed on sacral decub stage III. Foley patent, to gravity drainage clear amber yellow urine, medium yellow. Midline abd incision CTA w/ steri strips intact. HOB ↑, enc IS, IV to (R) FA patent & intact. ∅ indications of resp distress noted. Restraints per EPW protocol, ∅ breakdown noted, restraint pants. Will continue to monitor pt. [redacted]

13 Oct 03 @ 1930 = VSS, ∅ c/o pain, O2 sats [redacted], ∅ S/S resp distress, LCTAB, OOB & ambulates c̄ walker PRN s̄ difficulty, steri strips to midline abdominal wound CDI, Duoderm to sacral wound CDI, IV to (R) FA running D5NS c̄ 20meq KCl s̄ difficulty, Foley to gravity draining amber colored urine, x2 restraints when in bed s̄ skin breakdown noted, will continue to monitor. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW

[redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
1000	– Pt 8 hour post Foley catheter removal has not voided orders to in and out cath if greater than 500 leave in place urine output 400 cc. Given pt. inability to urinate and mental state Foley cath was left to gravity dark yellow urine. Will cont to monitor [redacted] b(6)-2 [redacted] grounds.
	(1815) I concur c̄ above assessment. [redacted] WA
(1940)	Pt awake, VSS, ϕ complaints, amb x 1 in hallway. Foley to gravity draining dark amber urine. Q2 turns. Sacral decub c̄ W-D. drsg S/S. LCTAB, HRRR, ⊕BS x4. ⊕ pedal pulses, O2 sats 95-97%. RA. D5NS c̄ 20 meq KCL cont. 2 pt restraints on S̄ compromise to skin or circulation. Will monitor [redacted] 91WM16. b(6)-2

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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[redacted]
b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Oct 03 0700	-Assumed care of pt. A+O x3. VSS. Ø c/o pain or discomfort @ this time. Lungs CTA HRRR Active BS decreased appetite. Tolerating PO. Foley to gravity dark amber urine. QS. PIV @ ARM D5NS c̄ 20meq KCl. Encourage Q2° position change breakdown to sacral area. stage II open to air. Position on stomach @ this time AM care given bed bath. Will cont to monitor [redacted] (1500) I concur c̄ above assessment. b(6)-2 [redacted]
(2015)	Pt awake, VSS, Ø complaints @ this time. LCTAB, HRRR, ⊕BS x4, amb. in hallway c̄ walker x 15 min. foley draining dark yellow urine. Q2° turns. ~~to~~ sacral breakdown noted (OTA) stage II. D5NS c̄ 20meq KCl infusing @ this time to ⓡFA. IS encouraged. 2 pt restraints on 3 compromise to skin/circulation will monitor. b(6)-2 [redacted] 91WM6
(0200)	foley d/c'd. due to void in 8° or less. (1000) 18OCT03 b(6)-2 [redacted] 91WM6
18 OCT 03 0700	-Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort @ this time. Continue Q2h position change breakdown to sacral area stage II healing open to air. lungs clear O2 sats 96% RA Non productive cough. HRRR. Active BS. Tolerates PO Ensure c̄ meals. ~~Voiding QS~~ Due to void 8° post foley removal 1000 this am. Will cont to monitor b(6)-2 [redacted]

[redacted] b(6)-4

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15 OCT 03 2100	VSS. AO. Pt. translated that he was depressed for being here. Placed upright in bed. LSCLAB. ↓ diminished lungs. Encouraged to deep breathe. IV D5 NS c̄ 20K @ 125 cc/hr. OOB to ambulate c̄ use of walker for 15 min c̄ minimal assistance. Abdominal incision CDI. b(6)-2 [redacted]
16 OCT 03 @ 0700	Assumed care of pt. A&O x 3. Stage II decubitus ulcer x 2 to buttocks bilaterally. Duoderm applied p̄ AM care. Pt. ambulated to BR c̄ walker and assistance. Pt. has Foley to gravity, amber urine. Pt. has IV to (R) FA, D5 ~~1/2~~ NS @ 125 cc/°. All other assessments WNL. EPW restraint protocol used. (Ø) skin breakdown noted, [redacted]
16 OCT 03 @ 1745	Pt.'s urinal emptied, dark amber urine, 750 cc. [redacted] b(6)-2
16 OCT 03 2335	VSS. AO. Sparing amount of food to himself. LSCLAB. Abdominal incision CDI. BS (+) x 4. IV removed to (R) arm. HD compful placed to sacral, stage I decubitus sacral ulcer. (+) pulses in all extremities. Mentation still questional. Voiding light amber urine @ BS c̄ FTG. Skin intact to all remained extremities. Tolerated PO meal for meal. IV D5 NS c̄ 20K @ 125 cc/hr. [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. ICW #1

b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Oct 03	Transfer Summary Iraqi Prison Hospital
	Admit Date 19 Sep 03
	DC Date 19 Oct 03
	Dx 1) GSW from Right Flank 3) Acinetobacter Bilateral
	2) Fractured Sacroiliac joint over lobar pneumonia
	Procedure – Xlap 4) Long return recovery Pt
	Hospital Course – 40 YOM Iraqi soldier GSW to (R) Flank
	Hemodynamically unstable taken to OR Xlap
	Findings hemoperitoneum. No vascular or bowel injury
	Bleeding from small blood for sacroiliac region.
	Post Op course complicated by development of Acinetobacter
	Sepsis from Bilateral lower lobe pneumonia. Treated
	14 day course of Rocephin + Tobramycin with good
	response. Extubated o/a 5 October. Completed
	Antibiotics. No further fevers. Currently Need medically
	appropriate to go to EPW camp.
	MEDS Percocet 1-2 po Q 6° prn pain.
	[redacted] b(6)-2

#[redacted] b(6)-4

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

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19SEP 03	OP Note
0400	indication surgical Aid with hypotension
	procedure ex LAP exploration of retroperitoneum
	(2) medial visceral Rotation
	surgeons [redacted]
	Anesth GEMA Bently/Lyons
	Fluids - 3000 cc LR
	1200 NS to KW-2 A11
	1u PRBC
	Findings. (1) small Amt of Hemoperitoneum. (2) Large
	(R) Retroperitoneal Hematoma. NO Major vascular
	or urologic injury in Retro. Bullet tract
	through Iliac wing/sacrum/subcutaneous
	para spinous muscles, surgical placed Drs — placed
	comp note
	Dhpo evacuated to ICU in good cond.
	[redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Oct 03	Pt transferred to ward last night. Rem off O2. look good. will DC Foly tomorrow. Needs to complete additional week antibiotics
	[redacted] b(6)-2

b(2)-2 NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 0120 | TIME 0120

TRANSPORTATION TO FACILITY

SEX: M

AGE: 39 ~~40~~

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: ~~[illegible]~~ DIAZEPAM 10 mg

ALLERGIES: ϕ

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW ABD ⊕ smoking

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 0120 b(4)-2

INITIALS: [redacted]

VITAL SIGNS

TIME	0125	0130	0135	0140
BP	74/31	60/36	60/32 mom	54/25
PULSE	96	96	98 SR	96 SR
RESP		20		
TEMP				
WT	160 lbs			

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
~~0130~~	IV (L) AC D5				

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)*

EPW [redacted]

b(4)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

A+O×3. HRRR - SR on monitor. Abd distended

0130 2 Large bore IV started - blood drawn

8.5F Femoral line started

GSW to (R) abd

0140 - TO OR

COI	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
		PROVIDER SIGNATURE AND STAMP
DIAGNOSIS		CODES

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

b(4) - 4

[redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted]

Icu # 2

VENTILATOR FLOW SHEET

8 ETT
22cm @ teeth

Pt # [redacted]

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
1530	26 Sept 03	Simv	14	800	100	5	29	14	140	98	125/76							R [redacted]
1539	26 Sept	Simv	14	800	100	10	38	16	124	95	90/52							[redacted]
26 Sept	2159	Simv	14	800	80	10	30	14	120	99	94/54							[redacted]
27 Sept	0020	SIMV	12	800	60	10	36	12	112	98	117/65	7.48	30.5	96	-1	23	98	[redacted]
	0145	SIMV	12	800	55	10	33	12	108	98	110/60							[redacted] Albneb
	0610	SIMV	12	800	50	10	36	12	105	97	123/58	7.43	39	137	2	26	99	[redacted]
	0800	SIMV	12	800	50%	10	32	12	113	98	124/67							[redacted]
	1006	SIMV	12	800	50	10	27	12	120	97	128/61							[redacted]
	1400	SIMV	12	800	50	10	32	12	121	97	141/62							[redacted]
	1527	SIMV	16	800	60	10	29	16	111	96	125/61							[redacted]
	1824	SIMV	16	800	60	10	40	19	116	97	136/50							[redacted]
	1924	SIMV	16	800	70	10	41	16	115	95	118/60							SX Albneb [redacted]
	0020	SIMV	16	800	60	10	37	17	106	95	120/53							[redacted]
	0230	SIMV	16	800	55	10	29	16	113	97	130/58							SX - Alb neb [redacted]
	0450	SIMV	16	800	55	10	41	17	110	95	128/60							SX [redacted]
	0620	SIMV	16	800	50	10	30	17	116	98	130/71							[redacted]
	0800	SIMV	16	800	50	10	28	16	108	97	130/58							[redacted] Alb neb [redacted]
	1000	SIMV	16	800	50	10	31	16	103	96	124/68							[redacted]
	1200	SIMV	16	800	50	10	30	16	114	100	124/67							[redacted]
	1400	SIMV	16	800	50	10	34	21	115	98	124/64							SX NEB [redacted]
	1800	SIMV	16	800	50	5	33	16	114	98	122/72							[redacted]
	1942	SIMV	16	800	50	5	39	19	110	99	119/62							[redacted]
	2007	SIMV	16	800	50	5	37	29	119	97	147/62							[redacted] Coarse Alb 4x [redacted]
	0015	SIMV	16	800	50	5	34	17	113	98	115/64							nurse [redacted]
	0330	SIMV	16	800	50	5	32	17	114	98	111/64							[redacted]
	0540	SIMV	16	800	50	5	30	20	112	95	115/63							[redacted] Alb + Atro [redacted]
	0800	SIMV	16	800	50	5	35	16	111	97	108/59							[redacted]
	1000	SIMV	16	800	50	5	30	16	111	98	112/68							[redacted]
	1525	SIMV	16	800	50	10	36	16	127	97	123/72							[redacted]
	1818	SIMV	16	800	60	10	38	17	123	94	106/58							OH
	1942	SIMV	16	800	60	10	36	17	126	96	92/54							Alb / Atr : Bs ↓ [redacted]
	2149	SIMV	16	800	55	10	37	17	112	96	89/53							[redacted]
	0020	SIMV	16	800	50	10	39	23	117	96	125/78							Alb 4x : SX [redacted]
	0155	SIMV	16	800	50	10	36	16	113	99	114/71							Alb + Atro : [redacted] [redacted]
	0359	SIMV	16	800	50	10	47	17	100	100	108/63							Alb neb [redacted]

MEDCOM - 19593

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 30 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): ? 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): ?

4. PROPOSED SURGICAL PROCEDURE:
Exploratory Lap.

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

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

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

[redacted] PW
b(6)-4

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

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

[redacted] b(w)-2 19 Sept 03 DATE

11. POSTOPERATIVE EVALUATION:

able to move - aware. able to respond to verbal stimuli.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED (Signature and Title)
[redacted] MA	[redacted] MA
DATE: 19 Sept 03 TIME: 01	DATE: 19 Sept 03 TIME: 0350

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATIN[illegible]M
VIA Litter BY Anesthesia

2. PATIENT IDENT[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] (Emergency)

3. DATE 19 Sept 03 TIME PATIENT ARRIVED IN SUITE 0140

4. PATIENT IN ROOM TIME 0140 b(6)-2 NUMBER TRAUMA OR

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt able to move

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [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

Pt placed in OR bed on arm board L 90° strapped strap above knees and PPP.

COMMENTS:

8. SKIN PREPARATION

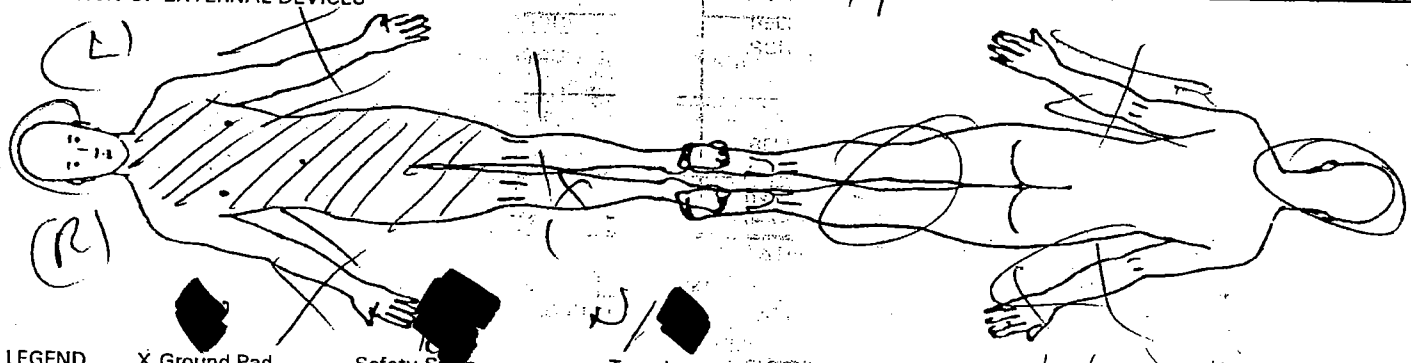
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine / Betadine b(6)-2
SITE: Neck BY WHOM:
SITE: Knees BY WHOM: [redacted]

COMMENTS: Spooling of Solution with

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] EPW

b(6)-4

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

☑ ESU NO: Valley Lab 40 TRAUMA Room
GROUND PAD: BRAND Valley Lab Pad
LOT NO: 48936 2003/03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

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): Nacl

OTHER ORDERS

	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JCF Foley	2. 400 cc Hemovac	3.
SITE	1. Bladder (Cath)	2. Abdomen (R) flank	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8 Steri-strips
Tape Benzoid

19. ADDITIONAL INFORMATION
S: [redacted] / [redacted] /
A: [redacted] / [redacted]

Bowel sts clear, dry intact, pre-post op

20. OPERATION(S) PERFORMED
Exploratory lap

21. PATIENT TRANSFERRED TO ICU TIME 0335 METHOD Cart

[redacted]SE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87

b(6)-2

MEDCOM - 19597

USAPA V1.00

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 4

SECTION I - PATIENT ASSESSMENT

DATE: 8 Oct 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY:

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 _____

Procedure/Diagnosis _____ Anesthesia (Specify): _____

LOC _____ B/P _____ P _____ R _____ T _____

Dressing/cast _____ Neurovascular checks _____

Intake (IV, po) _____ Tubes _____

Medication _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200																
BP ARTERIAL LINE																	
BP CUFF	103/60																
TEMPERATURE	98.0																
PULSE	89																
RESPIRATORY RATE	16																
OXYGEN (L/%)	0																
PULSE OXIMETER	97%																
O2 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:	1000	1200						
PAIN INTENSITY (10 / 5 / 0)	0							
MED ADMINISTERED (Y/N)	N	NA						
RELIEF ACCEPTABLE (Y/N)	N/A							

OTHER

TIME:	1000	1200						
FINGER STICK GLUCOSE	N/A	NA						
INSULIN (Y/N)	↓							

SPECIAL NEEDS

	TIME: 1000		
*Skin breakdown prevention	N/A		
*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: S/P GSW abd

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

S[illegible]N II - PATIENT ASSESSMENT - REVIEW OF S[illegible]AS

DIRECTIONS: A check ✓ in the small [illegible]licates patient assessment criteria have been [illegible] If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1000 INITIALS: [redacted]	TIME: INITIALS:	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.	☑	☐	☐
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.	☐ Foley D/C'd DTV@ 1800	☐	☐
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.	☐ Midline ABD incision steri-strips OTA	☐	☐
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: 1000 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 8 hr: PRN	IV patency ✓ q hr:	IV patency ✓ q hr:
IV site care provided: assessed	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: *AC / OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: D5NS c̄ 20 Kcl @100cc/hr.	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	1					
COLOR	NM					
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:	D		
ID visible/legible		[redacted]		
Orient to environment prn		[redacted]		
Side rails (2/4) up		N/A		
Bed position low				
Call light within reach				

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED: 0%	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, 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: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EBN [redacted] b(6)-4	[redacted]	b(6)-2	D

N RECORD - PATIENT ACTIVITIES I HEET

For use of this form, see MEDCOM Circular 40-

SECTION I - PATIENT ASSESSMENT

PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY:

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time 1740 To ICW2 From ICU2 Anesthesia (Specify):

Total ER/RR/PACU time Physician B/P P R T

Procedure/Diagnosis Neurovascular checks

LOC Tubes

Dressing/cast Steristrip Abd inc Voided ☐ No ☐ Yes Amount:

Intake (IV, po) Output (EBL, other)

Medication

Other Received By

Report From

VITAL SIGNS															
TIME:	1740	2000	1200	0400											
BP ARTERIAL LINE															
BP CUFF	118/64	100/60	100/66	90/60											
TEMPERATURE	97.1	97.8	97.8	990											
PULSE	94	97	88	87											
RESPIRATORY RATE	18	18	18	20											
OXYGEN (L/%)	0														
PULSE OXIMETER	96%	94%	94%	94%											
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:		1740	2000	0400											
PAIN INTENSITY	10														
	5														
	0	*	α	1											
MED ADMINISTERED (Y/N)		N													
RELIEF ACCEPTABLE (Y/N)		N/A													

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: S/P GSW Abd

DRG: ADMISSION DATE:

LOS: EXPECTED RELEASE:

CASE MANAGER:

PRIMARY CARE MANAGER:

ISOLATION REQUIRED (Specify):

PREVIOUS EDITIONS ARE OBSOLETE

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

MEDCOM - 19601

II - PATIENT ASSESSMENT - REVIEW OF S

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1740 INITIA[redacted]	TIME: 1930 INITIA[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.	☒	☑ 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.	☐ non-productive cough	☐ nonproductive cough Pneb tx	☐
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.	☐ Steri-strips to Abd.	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley c̄ clear amber urine	☐ Foley c̄ clear amber urine qs	☐
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.	☐ Activity amb c̄ assistance Pt transferred by litter	☐ Amb c̄ assist TID Pt c̄ weakness to (B) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Abd incision c̄ steri-strips no drainage	☐ abd incision midline c̄ steri-strips SCDI no drainage	☐
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: 1740 INITIALS: [redacted]	TIME: 1930 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q	6 hr:		
IV site care provided:	Assess/flush		
IV tubing changed:			
IV Site #1:	(L) AC — OK	(L) AC — OK	
IV Site #2:	(R) FA — OK	(R) FA — OK	
Comments:		D5NS @ 100° to (L) AC	

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

SECTION III - PATIENT INTERVENTIONS & TEA

SITE: TIME:						
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; O-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

	TIME: 1740	1930		
SAFETY: ID band visible/legible	[redacted]			
SAFETY: Orient to environment prn		NA		
SAFETY: Side rails (2/4) up				
SAFETY: Bed position low				
SAFETY: Call light within reach				
OTHER: Review & post lab results				
OTHER: Notify MD abnormal labs				
OTHER: Incontinent urine/stool				
OTHER: Linen change prn				
OTHER: Turn/reposition q2h				
OTHER: ROM q2h if immobile				
OTHER: Antiembolic hose				

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 8
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ 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: 2 AC	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1740 INITIALS: [redacted]	TIME: 1930 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - CALL FOR ASSIST - ~~AM~~ WARD ORIENTATION	CONTENT: - Call for assist - pain management	CONTENT:
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] b(6)-2	1W/AM 18-06

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1740	Abd mc inc	Steri-Strip INTACT	Assess
	1930	Midline incision to abd	Open to air, ~~Steristrips~~ CDI	Assessed

SECTION IV - NOTES

70CT03 1740 Pt admitted from ICU2. Stable condition. NKDA.

70CT03 1930: Pt awake & alert. [redacted] Lungs sounds clear bilat, diminished to bases. non-productive cough, particularly in neb [redacted] b(6) - 2 AIC

(b)(2)-2

ICU2 Pt [redacted] 8cm ETT 26 @ lip

[redacted] **VENTILATOR FLOW SHEET**

Alb Q4 + Atro Q8

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
30ct	0800	SMV	16	800	40	5	26	16	91	97	83/49							
	1000	SIMV	24	800	40/45	5	18	25	101	100	84/64							RHR
	1200			EXT.														RR TX

MEDCOM - 19605

b(6)(7)(c)

ICU2 Pt [redacted] b(6)-4

8.0 ETT 26@ lip

[redacted] **VENTILATOR FLOW SHEET**

Alb Q4 + Atro Q8

b(6)-2

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
30 Sep	0610	Simv	16	800	45	10	37	16	110	98	106/64							[redacted]
	0800	Simv	16	800	45	10	36	16	109	98	109/64							
	1000	Simv	16	800	45	10	38	24	114	99	111/61							[redacted]
	1200	Simv	16	800	45	10	46	21	112	93	121/66							
	1400	Simv	16	800	45	10	40	17	106	97	125/62							
	1535	Simv	16	800	45	5	32	19	107	96	110/59							[redacted]
	1729	Simv	16	800	45	5	34	16	104	97	101/50							BBS coarse
	1945	Simv	16	800	45	5	34	25	118	97	148/83							Atr tx Sx OH
	2135	Simv	16	800	45	5	32	20	103	99	127/72							[redacted]
1 Oct	0050	Simv	16	800	45	5	39	30	116	95	130/75							Sx Odl
	0405	Simv	16	800	45	5	30	16	101	98	125/68							Pt awake + moving above
	0510	Simv	16	800	40	5	31	18	104	100	114/63							Alb + Atro + Sx UF 4
	0800	Simv	16	800	40	5	31	16	100	96	108/60							[redacted]
	1000	Simv	16	800	40	5	32	16	100	96	103/63							Alb + Sx @ 0630
	1200	CT				5	34											
	1400	Simv	16	800	40	5	34	16	97	99	84/81							[redacted]
	1531	Simv	16	800	40	5	33	19	108	98	84/74							
	1739	Simv	16	800	40	5	33	19	92	98	110/59							
	1927	Simv	16	800	40	5	33	16	101	98	122/6							BS coarse
	2124	Simv	16	800	40	5	38	28	124	96	144/72							Atro Sx
	2305	Simv	16	800	40	5	33	18	112	95	126/63							Sx Sx
2 Oct	0150	Simv	16	800	40	5	33	19	116	95	128/68							[redacted]
	0450	Simv	16	800	40	5	32	29	118	98	131/70							Alb + Atro + Sx
	0800	Simv	16	800	40	5	29	16	102	97	119/58							Alb + Sx
	1030	Simv	16	800	40	5	28	16	114	97	128/79							CTA
	1200	Simv	16	800	40	5	30	16	104	100	85/42							Sx Tx
	1430	Simv	16	800	40	5	37	19	106	98	95/48							[redacted]
	1538	Simv	16	800	40	5	34	30	112	94	100/51							Tx
	1800	Simv	16	800	40	5	33	22	105	96	100/52							Sx by nurse
	1948	Simv	16	800	40	5	29	16	98	97	97/51							Atro
	2128	Sim	16	800	40	5	29	17	104	97	96/54							[redacted]
	2336	Simv	16	800	40	5	28	15	99	98	98/53							Tx Sx OAH
	0130	Simv	16	800	40	5	33	23	103	98	90/46							Suctioning
	0330	Simv	16	800	40	5	28	20	101	97	93/50							but ETT BS shed coarse
	0535	Simv	16	800	40	5	36	16	99	96	96/50							Alb + Atro + Sx
																		[redacted]
																		Alb + Sx

MEDCOM - 19606

PT'S NAME #[redacted] 3

DATE: 04OCT03

	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	137/69	144/68	144/76	122/																			
BP NIBP	122/69	120/70	116/75		132/71	125/64	128/73	132/60	132/65	132/64	128/56	123/58	145/71	112/55	131/68	120/68	120/60	95/56	114/62	122/61	111/59	104/53	112/55
TEMP	99	98	99	99		99	98.7	98.4		99.5		99.6		99.4		100		100		99		99	
PULSE	110	101	104	103	101	96	111	100	99	109	101	108	104	110	102	104	107	102	101	103	103	96	92
RESP	30	24	26	26	36	39	24	41	49	36	39	40	50	35	34	36	40	40	38	42	38	36	24
SP02	95	96	95	94	93	96	92	94	93	90	90	90	94	94	92	94	94	100	100	99	99	100	99
FIO2	3L	[illegible]	3L	3L	3L	6L	6L	6L	6L	6L	6L	15L	15L	15L	15L	15L	15L	15L	15L	15L			
SOURCE	NC	[illegible]	NC	NC	NC	NC	NC	NC	NC	[illegible]	FM	NR	NR	NR	NR	NR	NR	vent					
Chest Pigtail											[illegible]		WOL	WOL	RJ	WOL	RJ		WOL		WOL		WOL
NT suction											[illegible]		WOL		RJ				RJ				
INPUT																							
IVD5½NS	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
E20meq KCl																							
NPB				200												100						100	
Heparin	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
PO		200																					
NGT																							
O.R. IN																							
SUB TOTAL			145		145	145	145	145	145	145	145	145	145	145	145	245	145	145	145	145	145	245	145
TOTAL	145	590	735	1080	1225	1370	1515	1660	1805	1950	2095	2230	2375	2510	2655	2900	3045	3290	3435	3580	3725	3970	4115
OUTPUT																							
URINE	200	160	140	160		400		180	200	200	140	180	225	200	175	250	150	175	150	225	150	125	125
NGT																							
STOOL																							
O.R. OUT																							
SUBTOTAL																							
TOTAL	200	360	500	660		1060		1240	1440	1640	1780	1960	2185	2385	2460	2710	2860	3035	3185	3410	3560	3685	3810
BALANCE																							

MEDCOM - 19607

PT'S NAME: [redacted]

DATE: 06 OCT 03

	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	141/78		123/68	132/71	1[illegible]/60	120/63	118/61	124/61			115/65	108/54	117/60	118/62	121/63	119/63	123/80	129/66	1[illegible]2	111	112	119	1[illegible]/65
BP NIBP																			59	58	54	60	
TEMP	98.3	98.4	98.7	98.6	98.4	98.6	98.4	98.4	98.6	98.4	98.4	99.2	98.8	99.0	98.5	98.5	98.9	98.2	98.6	98.4		98.8	
PULSE	107	96	94	99	101	97	94	92	94	95	95	93	91	92	89	92	107	103	95	96	98	94	95
RESP	12	14	28	30	36	27	28	23	23	29	30	23	26	23	27	18	33	33	24	26	25	26	27
SP02	93	96	96	98	94	97	97	99				97	96	98	97	98	95	95	96	99	96	95	96
FIO2																							
O2 rate	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	1L	1L	1L	1L	1L	4L	0.5L	.5l	.5l	.5l	.5l	.5l
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
																	up in Chair						
INPUT																							
IV																							
D5W ns 20cc	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
Heparin	20	20	20	20	20	20	20	20															
10PB				100																		100	
PO	240		240															240					
NGT																							
O.R. IN																							
SUB TOTAL		145	385	245	145	145	145	145	125	125	125	125	125	125	125	125	125	375	125	125	125	125	125
TOTAL	345	530	915	1160	1305	1550	1695	1840	1965	2090	2215	2340	2465	2590	2715	2840	2965	3340	3465	3590	3715	3840	3965
OUTPUT																							
URINE	200	200	200	200	220	160	170	200			130	130	160	200	200	150	275	200	200	225	250	300	200
NGT																							
STOOL																							
O.R. OUT																							
SUBTOTAL																							
TOTAL											130	130	160	200	200	150	275	200	200	225	250	300	200
BALANCE	200	400	600	460	1100	1200	1410	1640			1760	1880	2540	2740	2940	3090	3365	3565	3765	3940	4140	4540	4740

MEDCOM - 19608

PT'S NAME: # [redacted] D(3)-J

DATE: 05 Oct 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	118/58	117/63	129/69	112/62	114/61	114/63	120/63	114/67	121/67	126/72	118/64	136/68	149/78	107/56	114/55	144/75	151/78	127/70	129/55	127/63	121/65	117/64	117/64	123/
BP NIBP	110/64	107/50																						
TEMP	98	98	98.9	98.6	98.7	99.4	98.4	98.0	98.1	98.6	98.1	98.6	99.1					98.6			99.1			99.
PULSE	92	94	91	94	101	96	101	98	96	89	100	89	92	92	93	96	116	97	106	93	94	91	93	91
RESP	30	28	29	24	31	28	34	27	29	31	36	33	39	29	18	15	27	32	29	21	28	28	30	16
SP02	98%	98%	98%	98	97	96	98	92%	100	97	91	96	100	96	100	94	98	95	97	97	95	95	95	96
FIO2	40	40	40																					
O2 Rate	4L	4L	4L	4L	4L	4L	4L	6L	4L	4L	4L	4L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	4L
Route	Venturi	Venturi	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT																								
IV D5½NS 20K	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
H-Lyte	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
D/B/B				200													100					100		
PO		360				400					240													
NGT																								
O.R. IN																								
SUB TOTAL													145	145	145	145	245	145	145	145	145	245	145	14
TOTAL	145	680	795	1135	1380	2935	3075	3315	3740	3585	3985	3880	4025	4170	4315	4460		4850		5040		5490		56
OUTPUT																								
URINE	200	200	200	160	180	100	100	100	140	100	100	100	300	120	260	190	–	–	370		850		340	12
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL													300	120	260	190	–	–	370		850		340	12
TOTAL	200	400	600	760	940	1040	1140	1240	1380	1480	1580	1680	1980	2600	2860	3050			3420		3770		4110	42
BALANCE																								

MEDCOM - 19609

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

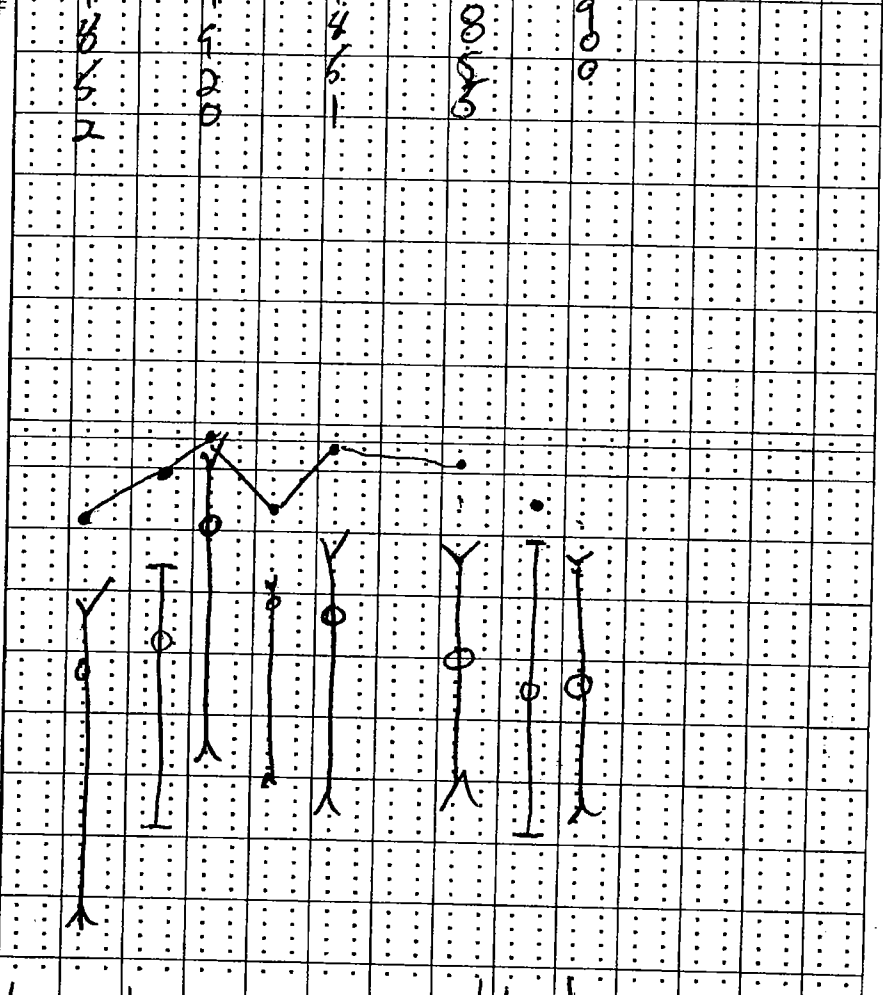
POST- DAY

MONTH-YEAR | DAY: 14 Oct 03 | 15 Oct | 16 Oct | 17 Oct 03 | 18/18

19 | HOUR: 0700 | 08 | 0700

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.

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

#[redacted]

b(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

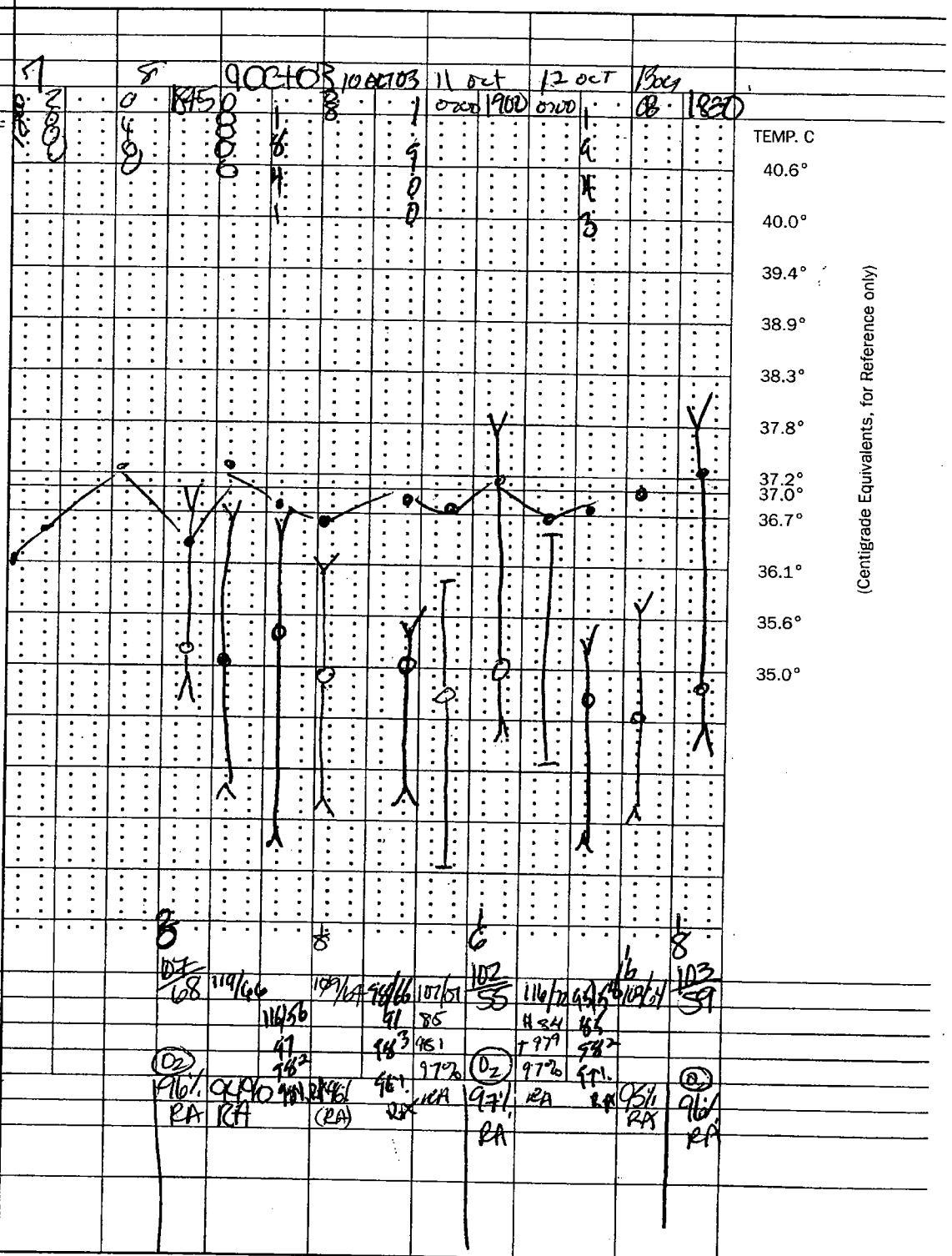
HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT DAY

19 2003 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.

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 180CT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1900	H2O	200	
1900	juice	240	440cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
?	1000	D5NS c 20KCl	950cc	0200	950cc

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0100	amber urine	700	700cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

#[redacted]

b(6)-4

Ward/Section: ICU2	REQ [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 07Oct	TIME 0330	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ 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)	
Set Rate			
Other			

Urinalysis

TEST	RESULT	REF. RANGE
Color	b(6)-4	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	

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC, PT PTT, chem 8

REPORTED BY:	DATE:	LAB ID NO.:

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

Ward/Section: ICW #1

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

DATE: 15 OCT

TIME: 1110

SSN/PREFIX/PSEUDO SSN: [redacted] EPW b(6)-4

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dl
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (v
PO2		80-105 mmHg (N/A (ven)
TCO2		23-27 mmol/L (24-29 mmol/L (
HCO3		22-26 mmol/L (23-28 mmol/L (
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANG
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

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

15/10/03 11:25

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3204AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	101*	26-84	U/L
ALT	15	10-47	U/L
AMY	103*	14-97	U/L
AST	21	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	127	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	104	73-118	MG/DL
TP	7.9	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0, ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

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

15/10/03 11:24

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: b(6)-2 3152AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	102	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	53	39-380	U/L
~~NA+~~	~~128~~	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0, LIP 0, ICT 0

NA 133

REMARKS: CBC + chemistry

REPORTED BY:

DATE:

LAB ID NO.:

b(6)-2

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

Unit/Section: ICW#1	REQUESTING PHYSICAN: [redacted]	DATE: 15 Oct	TIME:
SSN/PEEUDO SSN: [redacted] EPW			

b(6)-4

NAME, FIRST, MI. b(6)-4 EPW# [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ 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)
Set Rate		
Other		

Coagulation Studies

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

Urinalysis Foley

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.020	N/A
Bld	mod	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	2+	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Miscellaneous 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		

Macroscopic Urinalysis

SSA - Trace TRACE-BACT
3-5 RBC
~~[illegible]~~ - EPIRELLS-10

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

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

DATE: 15 Oct 03

LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: EPW [redacted] b(6)-4	DATE: 19 SEP 03	TIME: 0125	SSN/PSEUDO SSN: [redacted] b(6)-4

(ESTAT)

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

Misc. Chemistry

TEST	RESULT	REF
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

```
======= PICCOLO =======
19/09/03                    01:46
REFERENCE RANGE:            MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #:                 3142AA4
OPER #: [redacted]          DR #: 000
SERIAL #: b(6)-2 [redacted]
.......................................
ALB   2.9*  3.3-5.5   G/DL
ALP   39    26-84     U/L
ALT   18    10-47     U/L
AMY   56    14-97     U/L
AST   33    11-38     U/L
TBIL  0.3   0.2-1.6   MG/DL
BUN   6*    7-22      MG/DL
CA++  7.6*  8.0-10.3  MG/DL
CHOL  110   100-200   MG/DL
CRE   1.3*  0.6-1.2   MG/DL
GLU   135*  73-118    MG/DL
TP    5.9*  6.4-8.1   G/DL

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

(Piccolo) Metabolic Panel

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

```
======= PICCOLO =======
19/09/03                    01:45
REFERENCE RANGE:            MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #:                 3145AA4
OPER #: [redacted]          DR #: 000
SERIAL #: b(6)-2 [redacted]
.......................................
GLU   127*  73-118    MG/DL
BUN   8     7-22      MG/DL
CA++  7.6*  8.0-10.3  MG/DL
CRE   1.6*  0.6-1.2   MG/DL
NA+   136   128-145   MMOL/L
K+    3.8   3.3-4.7   MMOL/L
CL-   104   98-108    MMOL/L
tCO2  23    18-33     MMOL/L

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

REM[redacted] b(6)-2

REPORTED BY:	DATE:	LAB ID N

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted] b(6)-4	DATE	TIME	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

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

UNIT	TYPE	CROSSMATCH

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: AB pos

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN: b(6)-4	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE / TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
09/26/03              03:54 PM
REFERENCE RANGE:          MALE
PATIENT #: [redacted] b(6)-2
GENERAL CHEMISTRY 12
DISC LOT #:            3204AA1
OPER #: [redacted]     DR #: 000
SERIAL #: b(6)-4 [redacted]
...........................
ALB    2.3*   3.3-5.5    G/DL
ALP    70     26-84      U/L
ALT    59*    10-47      U/L
AMY    53     14-97      U/L
AST    42*    11-38      U/L
TBIL   2.1*   0.2-1.6    MG/DL
BUN    10     7-22       MG/DL
CA++   8.5    8.0-10.3   MG/DL
CHOL   93*    100-200    MG/DL
CRE    1.1    0.6-1.2    MG/DL
GLU    119*   73-118     MG/DL
TP     6.7    6.4-8.1    G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
09/26/03              04:21 PM
REFERENCE RANGE:          MALE
PATIENT #: [redacted] b(6)-2
METLYTE 8
DISC LOT #:            3152AA4
OPER #: [redacted]     DR #: 000
SERIAL #: b(6)-4 [redacted]
...........................
GLU    118    73-118     MG/DL
BUN    8      7-22       MG/DL
CRE    1.0    0.6-1.2    MG/DL
CK     331    39-380     U/L
NA+    ♦♦♦    128-145    MMOL/L
K+     4.1    3.3-4.7    MMOL/L
CL-    94*    98-108     MMOL/L
tCO2   22     18-33      MMOL/L

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

Na - 139 mmol/L

tCO2 | | 18-33 mmol/L

REMARKS:

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

b(6)-2

MEDCOM - 19618

Ward/Section: ICU 2	REQUESTING PHYSICAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST,MI. EPW # [redacted] b(6)-4		DATE 28/9	TIME 1700	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
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 x10³ 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)	
Set Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC / coags / ABG T: 101.1 FiO2 50%

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: b(6)-4 EPW [redacted]	DATE 28/9	TIME 1700	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
AL		
AM		
AS		
TB		
BU		
CA		
CH		
CR		
GL		
TP		
TE		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO2		

======= PICCOLO =======
09/28/03 04:41 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	128*	73-118	MG/DL
BUN	***	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	973*	39-380	U/L
NA+	***	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	95*	98-108	MMOL
tCO2	25	18-33	MMOL

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

Bun 9
Na 129

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS: met 8

REPORTED BY:	DATE: [redacted] 28 Sep 03	LAB ID NO.:

Ward/Section: CU2	REQUESTING PHYSICIAN: Dr. [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. b(6)-4 #[redacted]	DATE 04OCT03 TIME 0500	SSN/PEEUDO SSN: #[redacted]

(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:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICAN: Dr. [redacted] b(6)-2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. b(6)-4 # [redacted]		DATE 04OCT03	TIME 0500	SSN/PEEUDO SSN: # [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na	128	138-146 mmol/dL
K	3.6	3.5-4.9 mmol/L
CI	99	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	25	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	9	8-26 mg/dl
GLU	124	70-105 mg/dl
Creat	0.8	0.7-1.5 mg/dl
Hct	30	38-51% PCV
Hgb	10	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

b(6)-2

Ward/Section: ICU #2

REQUESTING PHYSICIAN: [redacted]

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

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

DATE 20SEP03 | TIME 0410 | SSN/PORIDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (vca)
PO2		80-105 mmHg (art) N/A (vca)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (vca)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (vca)
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 17

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
20/09/03 05:02
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	114	73-118	MG/DL
BUN	15	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	127*	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

REMARKS:

REPORTED BY:

DATE: 20SEP03

LAB ID NO.:

b(u)-2

Ward/Section: ICU2	REQUESTING PHYSICAN: Dr [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. # [redacted] b(u)-4	DATE 19Sept03 TIME 0415	SSN/PEEUDO SSN: # [redacted] b(u)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		
TEST		
GLU		
BUN		
CRE		
CK		
NA^+		
K^+		
CL^-		
tCO2		

PICCOLO
19/09/03 04:49
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(u)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(u)-2 [redacted]

GLU	149*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	1536*	39-380	U/L
NA+	135	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	111*	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/dl
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

RESULT	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

REMARKS: urine tox screen POS- BZO + OPI

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: ICU #2	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, [redacted] # [redacted] b(6)-4	DATE 19SEPT	TIME 2020	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic Panel

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

(Piccolo) Electrolyte 8

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

======= PICCOLO =======
19/09/03 20:23
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	122*	73-118	MG/DL
BUN	16	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	132	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

REMARKS: ABS

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST,MI. [redacted] b(6)-4		DATE 21 SEP 03	TIME 1121		SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH	7.46	7.31-7.45
PCO2	36.1	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	71	80-105 mmHg (art) N/A (ven)
TCO2	27	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	26	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	95	95-98%
BEecf	2	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
1CW2	Dr [redacted] b(6)-4	

LAST, FIRST, M		DATE	TIME	SSN/PSEUDO SSN:
[redacted] b(6)-2		26 Sep	0345	[redacted] b(6)-2

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA^{++}		
CHOL		1
CRE		0
GLU		7
TP		6

(Piccolo) Metlyte

TEST	RESULT	
GLU		73
BUN		7-2
CRE		0.6-
CK		39-3 30-1
NA^+		128-
K^+		3.3-4
CL^-		98-1
tCO2		18-33

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		3-118 mg/dl
		-22 mg/dl
		.0-10.3 mg/dl
		.6-1.2 mg/dl
		8-145 mmol/dl
		3-4.7 mmol/l
		-108 mmol/l
		-33 mmol/l

l Plus

		RANGE
		-5.5 g/dl
		84 u/l
		47 u/l
		97 u/l
		8 u/l
		1.6 mg/dl
		u/l
		.1 g/dl

e

		RANGE
		mmol/l
		mmol/l
CL		98-108 mmol/l
tCO2		18-33 mmol/l

```
======= PICCOLO =======
09/26/03            03:51 AM
REFERENCE RANGE:        MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #:             3145AA1
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: [redacted]
.........................
GLU   110   73-118   MG/DL
BUN    11    7-22    MG/DL
CA++  8.2   8.0-10.3 MG/DL
CRE   0.8   0.6-1.2  MG/DL
NA+   ~~112*~~ 130  128-145 MMOL/L
K+    4.6   3.3-4.7 MMOL/L
CL-   97*   98-108   MMOL/L
tCO2  23    18-33    MMOL/L

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

REMARKS:

REPORTED BY:	DATE.	LAB ID NO.:

Ward/Section: ICU2	REQUESTING PHYSICAN: Dr [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 23 Sep 03	TIME 2200	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
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)	
Set Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: CBC a.m. Lab and S/P transfusion 2 Units PRBCs

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU2	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST [redacted]	b(a)(4)	DATE 22SEP03	TIME 2200	SSN/PEEUDO SSN: [redacted]

(I-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
22/09/03 22:18
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(a) [redacted]

GLU	100	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	1342*	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

I-Stat
NA - 135
Bun - 8

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: Chem 8

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST MI: [redacted] b(6)-4	DATE 9/23/07	TIME 1010	SSN/PEEUDO SSN:

(STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 23 Sep 07	LAB ID NO.:

Temp 98.4
FIO2 45%

I-STAT

[redacted]

Name:______________

TCO2________ mmol/L

37C

pH________[illegible]

PCO2______[illegible] mmHg

PO2_________[illegible]

HCO3________[illegible]

BEecf________

sO2%________[illegible]

*Calculated

Sample Type_

[illegible] 18:[illegible]

[redacted]

I-STAT

[redacted]

Name:____________

TCO2_________26 mmol/L

37C

________7.47

PCO2______[illegible] mmHg

PO2_________75 mmHg

HCO3________25 mmol/L

BEecf________[illegible] mmol/L

sO2%________[illegible]

*Calculated

Sample Type_

1656P03 [illegible]

Oper: 1796

Physician:______________

Ser# [redacted]

Ver: [redacted]

I-STAT G3+

1800

[redacted]

b(6)-4

TCO2_________26 mmol/L

37C

pH________[illegible]

PCO2______[illegible] mmHg

PO2_____73 mmHg

HCO3_______25 mmol/L

BEecf________[illegible]

sO2%________

*Calculated

Sample Type_

1656P03 18:07

[redacted]

Physician:______________

[redacted]

SIMV 12 TV 800 PEEP 10 FiO2 50%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____28 mmol/L

At 37C

pH_____7.430

PCO2_____39.7 mmHg

PO2_____137 mmHg

HCO3_____26 mmol/L

BEecf_____2 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

27SEP03 05:10

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

SIMV 12 TV 800 PEEP 10 FiO2 40%

i-STAT G3+

Pt: [redacted]

Pt Name:_____ b(6)-4

TCO2_____30 mmol/L

At 37C

pH_____7.352

PCO2_____50.6 mmHg

PO2_____62 mmHg

HCO3_____28 mmol/L

BEecf_____2 mmol/L

sO2*_____90 %

*calculated

Sample Type_:

27SEP03 11:07

Oper: [redacted]

Physician: b(6)-2

Ser# [redacted]

Ver: [redacted]

SIMV 12 TV 800 PEEP 10 FiO2 50%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____30 mmol/L

At 37C

pH_____7.356

PCO2_____38.7 mmHg

PO2_____63 mmHg

HCO3_____28 mmol/L

BEecf_____3 mmol/L

sO2*_____90 %

*calculated

Sample Type_:

27SEP03 14:34

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

b(4)-4

ID: [redacted] 26-09-03
WB 15:51

			Patient Limits	
WBC	2.8 L	x10^3/uL	4.5	10.5
RBC	3.51 L	x10^6/uL	4.00	6.00
Hgb	9.6 L	g/dL	11.0	18.0
Hct	30.8 L	%	35.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	27.4	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	209. *	x10^3/uL	150.	450.
LY%	31.5 *	%	20.5	51.1
LY#	0.9 *L	x10^3/uL	1.2	3.4

ID: [redacted] 26-09-03
WB 03:56

			Patient Limits	
WBC	11.2 *H	x10^3/uL	4.5	10.5
RBC	3.61 L	x10^6/uL	4.00	6.00
Hgb	9.8 L	g/dL	11.0	18.0
Hct	31.6 L	%	35.0	60.0
MCV	87.5	fL	80.0	99.9
MCH	27.3	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	357.	x10^3/uL	150.	450.
LY%	18.4 *L	%	20.5	51.1
LY#	2.1 *	x10^3/uL	1.2	3.4

ID: [redacted] 26-09-03
WB 23:05

			Patient Limits	
WBC	20.8 H	x10^3/uL	4.5	10.5
RBC	3.81 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	33.4 L	%	35.0	60.0
MCV	87.5	fL	80.0	99.9
MCH	27.4	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	381.	x10^3/uL	150.	450.
LY%	4.6 *L	%	20.5	51.1
LY#	1.0 *L	x10^3/uL	1.2	3.4

ID: [redacted] 26-09-03
WB 18:33

			Patient Limits	
WBC	9.8	x10^3/uL	4.5	10.5
RBC	2.78 L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	24.9 L	%	35.0	60.0
MCV	89.4	fL	80.0	99.9
MCH	27.4	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	160. *	x10^3/uL	150.	450.
LY%	4.7 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL # [redacted] 09/26/03 11:07 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.8 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.22
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :11:06 PM
Card Lot :040302
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/26/03 03:53 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.5 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.3
~~Calculated INR = 1.47~~
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :03:51 PM
Card Lot :040302
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/26/03 11:10 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 30.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :11:07 PM
Card Lot :100208
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/26/03 03:56 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 27.4 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :03:54 PM
Card Lot :100208
Operator : [redacted]

b(6)-4

ID: [redacted] 25-09-03
WB 15:27

				Patient Limits	
WBC	9.3		x10^3/uL	4.5	10.5
RBC	3.27	L	x10^6/uL	4.00	6.00
Hgb	8.9	L	g/dL	11.0	18.0
Hct	28.9	L	%	35.0	60.0
MCV	88.4		fL	80.0	99.9
MCH	27.3		pg	27.0	31.0
MCHC	30.9	L	g/dL	33.0	37.0
Plt	339.		x10^3/uL	150.	450.
LY%	18.4	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

ID: [redacted] 24-09-03
WB 15:48

				Patient Limits	
WBC	11.0	*H	x10^3/uL	4.5	10.5
RBC	3.56	L	x10^6/uL	4.00	6.00
Hgb	10.1	L	g/dL	11.0	18.0
Hct	31.2	L	%	35.0	60.0
MCV	87.6		fL	80.0	99.9
MCH	28.2		pg	27.0	31.0
MCHC	32.2	L	g/dL	33.0	37.0
Plt	294.		x10^3/uL	150.	450.
LY%	14.2	*L	%	20.5	51.1
LY#	1.6	*	x10^3/uL	1.2	3.4

ID: [redacted] 23-09-03
WB 08:29

				Patient Limits	
WBC	9.5		x10^3/uL	4.5	10.5
RBC	3.25	L	x10^6/uL	4.00	6.00
Hgb	9.2	L	g/dL	11.0	18.0
Hct	28.9	L	%	35.0	60.0
MCV	88.8		fL	80.0	99.9
MCH	28.3		pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	215.		x10^3/uL	150.	450.
LY%	18.4	*L	%	20.5	51.1
LY#	1.8	*	x10^3/uL	1.2	3.4

ID [redacted] 24-09-03
WB 04:19

				Patient Limits	
WBC	8.9		x10^3/uL	4.5	10.5
RBC	3.39	L	x10^6/uL	4.00	6.00
Hgb	9.6	L	g/dL	11.0	18.0
Hct	29.7	L	%	35.0	60.0
MCV	87.6		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	32.4	L	g/dL	33.0	37.0
Plt	255.		x10^3/uL	150.	450.
LY%	19.7	*L	%	20.5	51.1
LY#	1.8	*	x10^3/uL	1.2	3.4

ID: [redacted] 23-09-03
WB 15:08

				Patient Limits	
WBC	8.9		x10^3/uL	4.5	10.5
RBC	3.30	L	x10^6/uL	4.00	6.00
Hgb	9.2	L	g/dL	11.0	18.0
Hct	28.9	L	%	35.0	60.0
MCV	87.6		fL	80.0	99.9
MCH	27.9		pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	234.		x10^3/uL	150.	450.
LY%	19.3	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

b(4)-4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____26 mmol/L

At 37C

PH_____7.450

PCO2_____36.3 mmHg

PO2_____50 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

sO2*_____87 %

*calculated

At Patient Temp

PH_____7.448

PCO2_____36.6 mmHg

PO2_____50 mmHg

Patient Temp: 98.9F

FIO2_____: 95

Sample Type_: ART

[redacted] 10:18

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

======= PICCOLO =======
25/09/03 03:56
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	105	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	131	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

b(4)-2

ID: [redacted]
WB

20-09-03
00:21

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	2.91 L	x10^6/uL	4.00	6.00
Hgb	8.3 L	g/dL	11.0	18.0
Hct	25.5 L	%	35.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	32.5 L	g/dL	33.0	37.0
Plt	148. L	x10^3/uL	150.	450.
LY%	19.9 L	%	20.5	51.1
LY#	1.5	x10^3/uL	1.2	3.4

ID: [redacted]
WB

20-09-03
04:58

			Patient Limits	
WBC	8.5	x10^3/uL	4.5	10.5
RBC	2.99 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	26.7 L	%	35.0	60.0
MCV	89.3	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	149. L	x10^3/uL	150.	450.
LY%	17.5 *L	%	20.5	51.1
LY#	1.5 *	x10^3/uL	1.2	3.4

ID: [redacted]
WB

20-09-03
12:33

			Patient Limits	
WBC	9.1	x10^3/uL	4.5	10.5
RBC	3.33 L	x10^6/uL	4.00	6.00
Hgb	9.5 L	g/dL	11.0	18.0
Hct	29.8 L	%	35.0	60.0
MCV	89.3	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	146. L	x10^3/uL	150.	450.
LY%	15.1 *L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

b(6)-4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____29 mmol/L

At 37C

PH_____7.487

PCO2_____36.5 mmHg

PO2_____110 mmHg

HCO3_____28 mmol/L

BEecf_____4 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

20SEP03 04:39

Oper: [redacted]

b(6)-2

Physician:_____

Ser# [redacted]

Ver: [redacted]

---

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____27 mmol/L

At 37C

PH_____7.557

PCO2_____29.3 mmHg

PO2_____62 mmHg

HCO3_____26 mmol/L

BEecf_____4 mmol/L

sO2*_____94 %

*calculated

Sample Type_:

20SEP03 19:08

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

---

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____133 mmol/L

K_____3.7 mmol/L

TCO2_____25 mmol/L

iCa_____1.04 mmol/L

Hct_____27 %PCV

Hb*_____9 g/dL

*via Hct

At 37C

PH_____7.517

PCO2_____29.9 mmHg

PO2_____81 mmHg

HCO3_____24 mmol/L

BEecf_____1 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

20SEP03 16:33

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

---

b(6)-2

ID: [redacted]
WB

21-09-03
15:49

				Patient Limits	
WBC	6.8		x10^3/uL	4.5	10.5
RBC	3.01	L	x10^6/uL	4.00	6.00
Hgb	8.7	L	g/dL	11.0	18.0
Hct	26.5	L	%	35.0	60.0
MCV	88.0		fL	80.0	99.9
MCH	28.8		pg	27.0	31.0
MCHC	32.7	L	g/dL	33.0	37.0
Plt	171.		x10^3/uL	150.	450.
LYM	19.4	L	%	20.5	51.1
LYM	1.3		x10^3/uL	1.2	3.4

ID: [redacted]
WB

22-09-03
04:41

				Patient Limits	
WBC	7.2		x10^3/uL	4.5	10.5
~~RBC~~	~~2.75~~	~~L~~	~~x10^6/uL~~	~~4.00~~	~~6.00~~
~~Hgb~~	~~7.7~~	~~L~~	~~g/dL~~	~~11.0~~	~~18.0~~
~~Hct~~	~~24.5~~	~~L~~	~~%~~	~~35.0~~	~~60.0~~
MCV	88.4		fL	80.0	99.9
MCH	28.7		pg	27.0	31.0
~~MCHC~~	~~32.5~~	~~L~~	~~g/dL~~	33.0	37.0
Plt	184.		x10^3/uL	150.	450.
~~LYM~~	~~19.7~~	~~L~~	~~%~~	20.5	51.1
LYM	1.4		x10^3/uL	1.2	3.4

ID: [redacted]
WB

22-09-03
10:35

				Patient Limits	
WBC	7.5		x10^3/uL	4.5	10.5
~~RBC~~	~~2.69~~	~~L~~	~~x10^6/uL~~	~~4.00~~	~~6.00~~
~~Hgb~~	~~7.7~~	~~L~~	~~g/dL~~	11.0	18.0
~~Hct~~	~~22.8~~	~~L~~	~~%~~	35.0	60.0
MCV	89.2		fL	80.0	99.9
MCH	28.9		pg	27.0	31.0
~~MCHC~~	~~32.4~~	~~L~~	~~g/dL~~	33.0	37.0
Plt	161.		x10^3/uL	150.	450.
~~LYM~~	~~17.7~~	~~L~~	~~%~~	20.5	51.1
LYM	1.3		x10^3/uL	1.2	3.4

ID: [redacted]
WB

22-09-03
22:19

				Patient Limits	
WBC	11.2	H	x10^3/uL	4.5	10.5
RBC	3.80	L	x10^6/uL	4.00	6.00
Hgb	11.0		g/dL	11.0	18.0
Hct	33.4	L	%	35.0	60.0
MCV	87.9		fL	80.0	99.9
MCH	29.0		pg	27.0	31.0
MCHC	33.0		g/dL	33.0	37.0
Plt	229.		x10^3/uL	150.	450.
LYM	15.2	*L	%	20.5	51.1
LYM	1.7	*	x10^3/uL	1.2	3.4

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

22/09/03 04:43

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: b(6)-2 [redacted]

.....

GLU	~~135*~~	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	~~0.5*~~	0.6-1.2	MG/DL
CK	1535*	39-380	U/L
NA+	136 ~~113*~~	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

b(6)-4

Pt: [redacted]
Pt Name:_____

Na_____137 mmol/L
K_____4.4 mmol/L
TCO2_____21 mmol/L
iCa_____0.98 mmol/L
Hct_____34 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
pH_____7.260
PCO2_____44.6 mmHg
PO2_____129 mmHg
HCO3_____20 mmol/L
BEecf_____-7 mmol/L
sO2*_____98 %
*calculated

At Patient Temp
pH_____7.275
PCO2_____42.6 mmHg
PO2_____123 mmHg

Patient Temp: 96.7F
Sample Type_:

19SEP03 04:23

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

i-STAT EG7+

Pt: [redacted]
Pt Name:_____

Na_____137 mmol/L
K_____4.6 mmol/L
TCO2_____26 mmol/L
iCa_____1.01 mmol/L
Hct_____27 %PCV
Hb*_____9 g/dL
*via Hct

At 37C
pH_____7.452
PCO2_____36.0 mmHg
PO2_____*** mmHg
HCO3_____25 mmol/L
BEecf_____1 mmol/L
sO2*_____*** %
*calculated

Sample Type_:

19SEP03 20:21

Oper: [redacted]

b(6)-2

Physician:_____

Ser# [redacted]
Ver: [redacted]

i-STAT G3+

Pt: [redacted]
Pt Name:_____

TCO2_____17 mmol/L

At 37C
pH_____7.282
PCO2_____34.5 mmHg
PO2_____279 mmHg
HCO3_____16 mmol/L
BEecf_____-10 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

19SEP03 02:37

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/19/03 01:50 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 21.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :01:47 AM
Card Lot :100208
Operator [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/19/03 01:52 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.6 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.19
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :01:51 AM
Card Lot :010301
Operator : [redacted]

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____22 mmol/L

At 37C

pH_____7.391

PCO2_____34.6 mmHg

PO2_____92 mmHg

HCO3_____21 mmol/L

BEecf_____-4 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

[redacted] 12:48

Oper: 0

Physician:_____

Ser# [redacted]

Ver: [redacted]

ID: [redacted] 19-09-03
WB 04:26

			Patient Limits	
WBC	10.0	x10^3/uL	4.5	10.5
RBC	3.85 L	x10^6/uL	4.00	6.00
Hgb	10.9 L	g/dL	11.0	18.0
Hct	33.6 L	%	35.0	60.0
MCV	87.3	fL	80.0	99.9
MCH	28.2	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	219.	x10^3/uL	150.	450.
LY%	17.7 *L	%	20.5	51.1
LY#	1.8 *	x10^3/uL	1.2	3.4

ID: [redacted] 19-09-03
WB 20:25

			Patient Limits	
WBC	9.0	x10^3/uL	4.5	10.5
RBC	3.06 L	x10^6/uL	4.00	6.00
Hgb	8.8 L	g/dL	11.0	18.0
Hct	27.0 L	%	35.0	60.0
MCV	88.4	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	32.5 L	g/dL	33.0	37.0
Plt	140. L	x10^3/uL	150.	450.
LY%	21.4 *	%	20.5	51.1
LY#	1.9 *	x10^3/uL	1.2	3.4

ID: [redacted] 19-09-03
WB 07:44

			Patient Limits	
WBC	14.1 H	x10^3/uL	4.5	10.5
RBC	4.02	x10^6/uL	4.00	6.00
Hgb	11.4	g/dL	11.0	18.0
Hct	35.1	%	35.0	60.0
MCV	87.3	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	249.	x10^3/uL	150.	450.
LY%	14.3 *L	%	20.5	51.1
LY#	2.0 *	x10^3/uL	1.2	3.4

ID: [redacted] 19-09-03
WB 17:02

			Patient Limits	
WBC	10.1	x10^3/uL	4.5	10.5
RBC	3.22 L	x10^6/uL	4.00	6.00
Hgb	9.2 L	g/dL	11.0	18.0
Hct	28.7 L	%	35.0	60.0
MCV	88.9	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	153.	x10^3/uL	150.	450.
LY%	17.6 *L	%	20.5	51.1
LY#	1.8 *	x10^3/uL	1.2	3.4

ID: [redacted] 19-09-03
WB 02:37

			Patient Limits	
WBC	14.1 H	x10^3/uL	4.5	10.5
RBC	4.12	x10^6/uL	4.00	6.00
Hgb	11.7	g/dL	11.0	18.0
Hct	36.1	%	35.0	60.0
MCV	87.5	fL	80.0	99.9
MCH	28.3	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	229.	x10^3/uL	150.	450.
LY%	24.3 *	%	20.5	51.1
LY#	3.4 *	x10^3/uL	1.2	3.4

ID: [redacted] 19-09-03
WB 01:39

			Patient Limits	
WBC	15.9 H	x10^3/uL	4.5	10.5
RBC	4.17	x10^6/uL	4.00	6.00
Hgb	11.5	g/dL	11.0	18.0
Hct	36.5	%	35.0	60.0
MCV	87.7	fL	80.0	99.9
MCH	27.5	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	288.	x10^3/uL	150.	450.
LY%	22.3 *	%	20.5	51.1
LY#	3.5 *H	x10^3/uL	1.2	3.4

i-STAT EG7+

Pt: [redacted] b(6)-4

Pt Name: b

Na_____129 mmol/L

K_____3.9 mmol/L

TCO2_____27 mmol/L

iCa_____1.01 mmol/L

Hct_____33 %PCV

Hb*_____11 g/dL

*via Hct

At 37C

pH_____7.588

PCO2_____27.6 mmHg

PO2_____112 mmHg

HCO3_____26 mmol/L

BEecf_____5 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.566

PCO2_____29.3 mmHg

PO2_____121 mmHg

Patient Temp: 101.1F

FIO2_____: 50

Sample Type_:

28SEP03 16:44

Oper: [redacted] b(6)-2

Physician:_____

Ser# [redacted]

Ver: [redacted]

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i-STAT EG7+

Pt: [redacted] b(6)-4

Pt Name: b

Na_____131 mmol/L

K_____3.6 mmol/L

TCO2_____28 mmol/L

iCa_____1.00 mmol/L

Hct_____31 %PCV

Hb*_____11 g/dL

*via Hct

At 37C

pH_____7.450

PCO2_____38.4 mmHg

PO2_____85 mmHg

HCO3_____27 mmol/L

BEecf_____3 mmol/L

sO2*_____97 %

*calculated

At Patient Temp

pH_____7.425

PCO2_____41.3 mmHg

PO2_____94 mmHg

Patient Temp: 101.6F

FIO2_____: 55

Sample Type_:

28SEP03 04:56

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

ID: [redacted] 28-09-03
WB b(6)-4 04:58

				Patient Limits	
WBC	16.5 H	x10^3/uL		4.5	10.5
RBC	3.89 L	x10^6/uL		4.00	6.00
Hgb	10.7 L	g/dL		11.0	18.0
Hct	33.9 L	%		35.0	60.0
MCV	87.3	fL		80.0	99.9
MCH	27.5	pg		27.0	31.0
MCHC	31.5 L	g/dL		33.0	37.0
Plt	409.	x10^3/uL		150.	450.
LY%	7.6	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

ID: [redacted] 28-09-03
WB b(6)-4 10:52

				Patient Limits	
WBC	14.5	*H	x10^3/uL	4.5	10.5
RBC	3.81	L	x10^6/uL	4.00	6.00
Hgb	10.4	L	g/dL	11.0	18.0
Hct	33.6	L	%	35.0	60.0
MCV	88.2		fL	80.0	99.9
MCH	27.2		pg	27.0	31.0
MCHC	30.9	L	g/dL	33.0	37.0
Plt	395.		x10^3/uL	150.	*450.
LY%	9.2	*L	%	20.5	51.1
LY#	1.3	*	x10^3/uL	1.2	3.4

ID: [redacted] 28-09-03
WB b(6)-4 23:12

				Patient Limits	
WBC	13.3	H	x10^3/uL	4.5	10.5
RBC	3.81	L	x10^6/uL	4.00	6.00
Hgb	10.4	L	g/dL	11.0	18.0
Hct	33.4	L	%	35.0	60.0
MCV	87.7		fL	80.0	99.9
MCH	27.3		pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plt	410.		x10^3/uL	150.	450.
LY%	7.9	*L	%	20.5	51.1
LY#	1.1	*L	x10^3/uL	1.2	3.4

ID: [redacted] 28-09-03
WB b(6)-4 16:46

				Patient Limits	
WBC	14.9	H	x10^3/uL	4.5	10.5
RBC	4.05		x10^6/uL	4.00	6.00
Hgb	11.1		g/dL	11.0	18.0
Hct	35.4		%	35.0	60.0
MCV	87.4		fL	80.0	99.9
MCH	27.5		pg	27.0	31.0
MCHC	31.4	L	g/dL	33.0	37.0
Plt	430.		x10^3/uL	150.	450.
LY%	11.3	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

ID: [redacted] 28-09-03
WB b(6)-4 00:14

				Patient Limits	
WBC	18.2	H	x10^3/uL	4.5	10.5
RBC	3.84	L	x10^6/uL	4.00	6.00
Hgb	10.6	L	g/dL	11.0	18.0
Hct	33.7	L	%	35.0	60.0
MCV	87.9		fL	80.0	99.9
MCH	27.5		pg	27.0	31.0
MCHC	31.3	L	g/dL	33.0	37.0
Plt	405.		x10^3/uL	150.	450.
LY%	7.0	*L	%	20.5	51.1
LY#	1.3	*	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 11:13 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.2 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.28
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :11:11 PM
Card Lot :040302
Operator : [redacted]

b(6)-4

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
[redacted] 09/28/03 04:47 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
~~Calculated INR = 1.31~~
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :04:46 PM
Card Lot :040302
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 11:16 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 36.2 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :11:13 PM
Card Lot :100208
Operator : [redacted]

b(6)-4

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 04:50 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 26.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :04:47 PM
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 12:22 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.7 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.21
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :12:21 AM
Card Lot :040302
Operator : [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
[redacted] 09/28/03 [illegible]

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :05:00 AM
Card Lot :040302
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
[redacted] 09/28/03 10:55 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.31
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :10:53 AM
Card Lot :040302
Operator : [redacted]

b(6)-4

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 12:25 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 32.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :12:22 AM
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 05:04 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :05:02 AM
Card Lot :100208
Operator : [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 10:58 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :10:56 AM
Card Lot :100208
[redacted]

b(6)-2