216

INPATIENT TREATMENT RECORD COVER SHEET (*For Plate Imprinting*)

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 (*Excluding Items 25 & 26*)

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. · NAME · GRADE
2	SEX · AGE · RACE · RELIGION · LENGTH OF SVC · ETS · PREVIOUS ADMISSION
3	FMP · SSN · ORGANIZATION · WARD
4	FLY STAT · RATING/DESG · DEPT/BEN · BRANCH/CORPS · UIC/ZIP · TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION · HOUR OF ADMISSION · CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE · PHONE NO. · DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

(b)(6)-2

32. UNIT BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: TRANS to Iraqi Hosp

26. DATE OF DISPOSITION: 4 Jul 03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Closed Head Injury (CHI) 873.8 ICD 9.
~~Motor Vehicle Accident (MVA)~~

☐ CHECK IF CONTINUED ON REVERSE

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

36. TOTAL DAYS ALL FACILITIES: a. ABSENT SICK DAYS; b. OTHER DAYS; c. CONV LV/COOP CARE DAYS; d. SUPPLEMENTAL CARE DAYS; e. BED DAYS; f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER: (b)(6)-2

(b)(6)-2

MEDICAL RECORDS OFFICER

EDITION OF 1 AUG 76 IS OBSOLETE.

DA FORM 1 MAY 79 3647-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

2003 OMFS Procedure Note

3JUL Dx: (L) parietal superficial lac x 4"

0805 Tx: irrigate, cleanse and staple lac closed (lac repair x 2)

Surg: Phillips Asst: Lt Gradore local and IV sed

monitors on. Irrigate lac c̄ N/S. Palpate - no crepitus No fx.

No debris - staple 1 cm and 4 cm lac closed.

Bactracin. Pressure

dressing. 2% lido c̄ epi 1:100,000

infiltrate 1.8cc. OK given to nurse.

pt snoring - monitored in ER. (b)(6)-4 (b)(6)-4 monitors.

100ug IV fentanyl for procedure

10 mg IV haldol (total of 2mg from admit to procedure)

1g IVPB ancef administered

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

509-114

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Staff Note - PP

3 July 03 1115 — 2 point restraints required for physical security measures - Detainee status and patient safety. 24 hour based on patient @ this time.

(b)(6)-2

FAMILY PRACTICE

4 July 03 0924 — Surgery note

S: Pt still slightly confused disoriented. Resting comfortably, C-collar in place

O: afeb VSS UOP 2090

Heart - RRR

Lungs - CTA (A)

Abd - soft, no RT, (+) BS

Head - loc site required

Neck - C-collar in place - X-rays (could not visualize C-7)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			(b)(6)-2
	LAST	FIRST (only)	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)

509-114

DATE	NOTES
4 Jul 03	Surg Staff Cont'd
0927	Alr: Pt. HO 2 S/P MVA c̄ CHI, scalp lac stable.
	(1) Leave C-collar in place. cannot clear due to inadequate films & diminished mental status (post-concussive)
	(2) Repeat f-u
	(3) Pt. stable for transfer
	(b)(6)-2
	MAJ MC
4JUL03	OMFS Note
	S/P lac scalp x ÷ repair in pt sp
	MVA c̄ CHI, scaraplac
	hemostatic; (+) edema @ crepitus
	see Gen Surg note
	stable for transfer.
	recommend staple removal 14 surg.
	(b)(6)-2
	PHILIPPE LTC DDS USN
04 Jul 03 0945	Nursing Notes: AM Assessment completed, see critical care flowsheet. (b)(6)-2 LPN

NSN 7540-01-075-3780

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) (b)(3)-1

LOG NUMBER

ARRIVAL		TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (Tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE: MONTH 07. YR. 03	TIME: 06 00	☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify)	?	☒ PATIENT ☐ OTHER (Specify)
				ALLERGIES: NKA
				HOME TELE. NO. (Inc. area code)

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

COMPLAINT(S) (Include symptom(s), duration)	SEX	AGE	POSSIBLE THIRD PARTY PAYER?
MVA / CHI	M		☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0600

VITAL SIGNS

0600	0600	
140/74	112/68	
74	74	
22	18	
93%	95%	

CATEGORY (See reverse)
EMERGENT
URGENT
NON-URGENT

ORDERS	INITS.	TIME
Spine	[redacted]	0400
Foley		
Dilaudid 2mg	[redacted]	06 16
Zofran 10mg		
Ketorolac 10mg	[redacted]	0727

ASSESSMENT/DIAGNOSIS
Closed head injury
Scalp Lacerations

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

Head lac from back

Adult Iraqi male brought in by US forces. Involved in MVA in process of being detained. Brought in as head injury. 126 / 149 / 44.7 / 161

A - patient able to talk
B - equal BS (B) 3.3
C - good pulses / BP p 117.304
D - GCS 14 (Eyes) moves purposefully when commanded to
E - Head Lacerations

10 Ty

IV established, C-spine precautions

2° Survey

HEENT: (L) occipital scalp lac, posterior scalp lac, PERRL, TMs clear and pharynx clear
Neck: ∅ step-offs
Chest: clear, sounds, small contusion (L) shoulder
Abd: soft, NT, ND
Pelvis stable
Back: ∅ tenderness or injury
GU: normal male
Ext: Normal range of motion, full ROM all joints

A/P (1) Closed head injury with scalp lacerations, wounds cleaned / irrigated, repaired with staples; Need to clinically clear C-spine at a later time

(CONTINUE ON SF 507, IF NEEDED)

A - ∅
M - None
P - None
L unknown
E - see HPI

FAST - Neg
Pelvis - ∅ Fx
CXR - poor insp effort, No pulmonary pathology, Healthy
C-spine - Lateral No Fx or dislocation thru C-6

ORDERS
Ancef 3 gm IV - 0815 MAM
Fentanyl 50mcg 0945 MAM
~~Dilaudid 10mg IV - 0727~~
Fentanyl 100mcg IV - 0744 MAM

DISPOSITION (Check all that apply)
HOME | FULL DUTY
QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.
MODIFIED DUTY UNTIL: DAY | MONTH | YEAR
REFERRED TO (Indicate clinic)
EMERGENCY | TODAY
72 HOURS | ROUTINE
ADMIT TO HOSP. UNIT/SERVICE: ICU
CONDITION UPON RELEASE: IMPROVED | UNCHANGED | DETERIORATED
TIME OF RELEASE:

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

Iraqi Civ
Civ
Trauma

(b)(6)-4

PROVIDER AND ID STAMP (b)(6)-2 MAJ

INSTRUCTIONS TO PATIENT (Medications ordered, any limitations and follow-up plans)

EMERGENCY CARE AND TREATMENT
Emergency Room Copy

STANDARD FORM 558 (REV. 5-82)
Prescribed by GSA and ICMR
FPMR (41 CFR) 101-11.806-8

[illegible]	[illegible]	00	[illegible]	96%
0730	143/64	93	22	97%
	Placed on 2L N/C perm			
0744	127/73	99	20	100%
(0750 - Haldol 10mg IV - [illegible]) Fentanyl 100mcg IVP Dr (b)(6)-2 [illegible] staples head laceration.				
0800	142/82	88	24	98%
0815	121/55	84	22	96%
Ancef 1G m PB↑ 1L RL↑ TKO (500cc NS infused) complete				
0830	/	78	24	98%
Labs - CBC, I Stat 8				
0845	104/62	77	22	100%

0900: Pt to Xray

0945: in Xray combative - unable to move tablet to litter.
119/60 HR 75 RR 16 98% Fentanyl 50mcg IVP x1

0950: Transfer pt from Xray to ICU #2. Report to MAJ (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 MAJ AN	(b)(6)-2
(b)(6)-2 Cpt AN	
(b)(6)-2 1Lt/A	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAJ AN	ICU 2	3 Jul 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R										2				2				2					2	
	RADIAL L										2				2				2					2	
	DORSALIS PEDIS R										2				2				2					2	
	DORSALIS PEDIS L										2				2				2					2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale											1 3 8				2 3 9				1 3 8					1 3 8	
EDEMA											Ø				Ø				Ø					Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)											✓				✓				✓					✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)											✓				✓				✓					✓	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE														✓										
	ORAL CARE																								
MOBILITY	BEDREST														✓				✓					✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																							✓	
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE										NTA				NTA				NTA					NT	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended										2				2				2					2	
BOWEL SOUNDS (active all quads)											✓				✓				✓					✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT															✓				✓					✓	
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
Scalp Lac	Surgical Wounds										✓				✓				✓						
	Rashes, Lac's, etc																							✓	
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18ga IV	(R) AC	3 jul 03	CDI

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open											4				4		4		4		4			4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response											UTA				UTA		4		4		4			5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response											5				5		5		5		5			5	
GLASCOW COMA SCALE (A+B+C)															13		13		13		13			14	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R										2+				2+		2+		4+		4+			4+2	
	L										2+				2+		2+		4+		4+			4+2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE										5				5		5		5		5			5	
	LUE										5				5		5		5		5			5	
	RLE										5				5		5		5		5			5	
	LLE										5				5		5		5		5			5	
GRIP (S) Strong (W) Weak (-) absent	R										S				S		S		S		S			S	
	L										S				S		S		S		S			S	
RESPIRATIONS	REGULAR										✓				✓		✓		✓		✓			✓	
	IRREGULAR																								
	UNLABORED										✓				✓		✓		✓		✓			✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL										5				5				5					5	
	LUL										5				5				5					5	
	RLL										5				5				5					5	
	LLL										5				5				5					5	
	BOTH BASES										1				1				1					1	
COUGH	NONE										✓				✓				✓					✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS										(b)(6)-2															

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000		78	24	108/61	93%												RA
1100																	
1200		81	20	113/67	94%												RA
1300																	
1400	*97.6	*103	42	*130/74	93												RA
1500					94												RA
1600		*98	20	*117/68	93												RA
1700					93												RA
1800		*107	28	*116/70	94												RA
1900					94												RA
2000		*101	14	*111/64	94												RA
2100																	
2200	100.4	*94	25	*120/74	96%												RA
2300																	
2400		92	18	115/73	94%												RA

	INTAKE									OUTPUT						
	LR (EMT)		NS (EMT)						Total						Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000	400 / 400	150 / 150	500													
1100		150 / 300														
1200		150 / 450														
1300																
1400		150 / 600								700						
1500		150 / 750														
1600		150 / 900														
8 HR									16 HR.						16 HR.	
1700		150 / 1050														
1800		150 / 1200														
1900		160 / 1360								1000 / 1700						
2000		150 / 1510														
2100		150 / 1660								90 / 1790						UA sent to Lab.
2200		150 / 1810								300 / 2090						
2300		150 / 1860														
2400		150 / 1910														
8 HR		1910							24 HR.	2090					24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Jul 03	1000		Admit Note: (S) Iraqi pt speaking arabic, unable to [(b)(6)-] ~~verbalize~~ assess subjective data (O) Pt arrived via litter from EMT accompanied by RN/medics. Admitted to ICU bed #8. Sedated see flowsheet for complete assessment data. Cervical collar in place, alignment maintained during transfer. Scalp lac stapled, bacitracin applied. unable to place dsg due to position of laceration. Upper & lower extremities c purposeful movement. (A) Pt s/p MVC c closed head injury. (P) monitor neurological status, sedated as needed. — [illegible]
	1100		Pt awake, agitated, upper extremities restrained, order obtained by [(b)(6)-2]. Ativan 2mg IV given for agitation c good effect. Attempted x2 to start 2nd IV, attempted 18 ga in (R) hand: success. — [(b)(6)-2] MNO/AN
3 July 03	1400		Rec'd report from prev. shift. Eyes closed. Resp deep & even, ∅ apparent distress. — [(b)(6)-2] Cpt AN
3 July 03	1430		16 Fr foley placed c̄ diff. Immediate return of 500cc clr yellow urine. Assessment completed. Interpreter states that he is confused & asking to go to the hospital. Cervical collar intact but is tossing around trying to get up & take restraints off. Haldol 5mg given for agitation. VSS. Continue to monitor. Lac on head is draining. Serosang fld. Chucks placed under head. — [(b)(6)-2] Cpt AN
3 Jul 03	1530		Thrashing around in bed. 2mg MSO4 given. — [(b)(6)-2] Cpt AN
3 July 03	1630		Resting quietly. VSS. ∅ distress. — [(b)(6)-2] Cpt AN
3 July 03	1915		Sitting & trying to get OOB & release restraints. Guards applied zipties. Circ remains good. c̄ sec. [(b)(6)-2] at bedside. Order for 5mg Haldol instead of Ativan. Cont to monitor. VSS p̄ Haldol. Currently resting. Eyes closed RR 16 — [(b)(6)-2] Cpt AN
3 July 03	2030		MSO4 for pain. Currently 8 of 10 per interpreter. Relaxed & eyes closed p̄ MSO4. RR 14-22 — [(b)(6)-2] Cpt AN
3 July 03	2200		Assumed care. Pt agitated. [(b)(6)-2] notified, ↑ Haldol order. Admin. Haldol 5mg & MSO4 2mg IVP. VSS. Denies pain. NS ~~LR~~ infusing @ 150 cc/h, BUE/BLE restrained. C-collar. [(b)(6)-2]

(b)(3)-1

DARNALL ARMY COMMUNITY HOSPITAL

LOS DATA	
DOA	3 Jul 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE 4 July 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2					2				2												
	RADIAL L			2					2				2												
	DORSALIS PEDIS R			2					2				2												
	DORSALIS PEDIS L			2					2				2												
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 8					1 3 8				1 3 8												
EDEMA				0																					
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓					✓				✓												
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				✓					✓				✓												
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST			✓					✓				✓												
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
C-spine precautions	SUPINE			✓					✓				✓												
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			✓					✓																
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended				2					2				2												
BOWEL SOUNDS (active all quads)				✓					✓				✓												
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓					✓				✓												
VOIDING CLEAR, YELLOW URINE q.s.				✓					✓				✓												
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
head lac	Rashes, Lac's, etc			✓					✓				✓												
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(B) AC	3 Jul 03	CDI

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES	
1 mm	=	Equal	0 = No Movement	Present	✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction		
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent	(blank)
			3 = Active: against gravity, but not against resistance		
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes	X
			5 = Full Strength against Examiners Resistance		
5 mm	R > L	Right Larger	DATE: 4 Jul 03	No Change from Previous Assessment	--

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			3		2		2		2		2		2												
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			4		4		4		4		4		4												
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			5		5		5		5		5		5												
GLASCOW COMA SCALE (A+B+C)			12		11		11		11		11		11												
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+		2+		2+		2+		2+		2+												
	L		2+		2+		2+		2+		2+		2+												
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		5		5		5		5		5		5												
	LUE		5		5		5		5		5		5												
	RLE		5		5		5		5		5		5												
	LLE		5		5		5		5		5		5												
GRIP (S) Strong (W) Weak (-) absent	R		S		S		S		S		S		S												
	L		S		S		S		S		S		S												
RESPIRATIONS	REGULAR			✓					✓				✓												
	IRREGULAR																								
	UNLABORED			✓					✓				✓												
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL			5					5				5												
	LUL			5					5				5												
	RLL			5					5				5												
	LLL			5					5				5												
	BOTH BASES			1					1				1												
COUGH	NONE			✓					✓				✓												
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2																						

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200		91	20	118/70	97%												RA
0300																	
0400		87	22	124/74	97%												RA
0500																	
0600	99.4	82	21	118/74	95%												RA
0700																	
0800	99.4	83	18	108/69	99%												RA
0900																	
1000																	
y 1100																	
1200	99.5	92	20	103/54	99%												
y 1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

	INTAKE									OUTPUT						
	NS								Total	Urine					Total	COMMENTS
0100	150															
0200	150 300															
0300	150 450									725 725						
0400	150 600															
0500	150 750									400 1125						
0600	150 900															
0700	150 1050															
0800	150 1200															
8 HR									8 HR.						8 HR	
0900	150															
1000	150 150 300									800 800						
1100	150 450															
1200	150 600															
1300	150 750															
1400	150 900															
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
04 Jul 03	0100		Pt agitated and pulling at restraints. Administered Haldol 5mg IVP per PRN order. [(b)(6)-2] 105/AN
	0215		Pt lifting head up and yelling out. Administered Ativan 2mg IVP per PRN order. [(b)(6)-2] 105/AN
	0220		Neuro ✓ pupils PERRLA. Because of sedation, unable to assess mental status. Pt responds to painful stimuli. [(b)(6)-2] 105/AN
	0300.		Pt lying comfortably in bed, sedated (pharmacologically) Restraints X4. CMS intact. Foley drainage quantity suff. Clear yellow urine and is secured to leg. VSS. on RA - SaO_2 96%. C-collar in place, but not fitted properly - pt does not allow staff to apply correctly. NS infusing @ 150 cc/h via (R) AC IV. Will continue to monitor. [(b)(6)-2] 105/AN
	0305		Head lac c̄ dried blood at site - unable to apply bacitracin or dsg as pt. combative. Sheet under head at this time. [(b)(6)-2] 105/AN
	0400		Neuro ✓ - Pt pharmacologically sedated. Sleeping at this time. Pupils +2, PERRLA. Moves all extremities spontaneously. Responds to painful stimuli. 4pt Restraints in place - good. CMS. [(b)(6)-2] 105/AN
	0600		Pt resting quietly @ this time. [(b)(6)-2] 105/AN
	0605		No A's on neuro assessment. BUE/BLE in place & secure. CMS good. [(b)(6)-2] 105/AN
04 Jul 03	0610		Assumed Care. Pt lying in bed, moaning, fighting wrist restraints, translator find patients speech to be incoherent. C-spine brace in place, pt turning head on own. (1) orbital abrasions and posterior skull laceration noted. Pt c̄ 4 point restraint, CMS intact. Neuro ✓, ~~pupils fixed~~ PERRLA,

(continued on next page)

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

04 Jul 03 0610 (Nursing Note: continued from previous page). Resp distress noted. 18g IV cath in (R) AC patent & infusing NS @ 150cc/hr ~~5~~ difficulty. Will continue to monitor. (b)(6)-2 LPN

04 Jul 03 9:50 Nursing Notes: Pt agitated and fighting restraints, able to calm down momentarily, but pt ↑ level of combativeness even c̄ positive assurance of pt's safety and health. Medicated pt c̄ 5mg Haldol IV per prn physicians order. Will continue to monitor. (b)(6)-2

04 Jul 03 14:05 Nursing Notes: Pt transferred to Iraqi Civilian Hosp c̄ personal belongings. Pt tolerated procedure well. (b)(6)-2 LPN

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.
(b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

509-114

STANDARD FORM 545 (rev. 10-75)
545-108

LABORATORY REPORT DISPLAY

(b)(6)-4

TEST(S)
SPECIMEN TAKEN
July 03 2100 A.M. P.M.

RESULTS	REQUESTED	(X)
	ROUTINE	
yellow	COLOR clear	
1.017	SPECIFIC GRAVITY	
0.2	UROBILINOGEN	
Mod	OCCULT BLOOD	
neg	BILE	
neg	KETONES	
100	GLUCOSE	
Trace	PROTEIN	
6.5	pH	
	MICROSCOPIC	
0-5	WBC	
5-10	RBC	
occasional	EPITH CELLS	
	CASTS: WBC	
	CASTS: RBC	
	CASTS: HYALINE	
	CASTS: GRANULAR	
Light	BACTERIA	
none	CRYSTALS	
Moderate	MUCUS	
Neg	NITRITE	
Neg	Leukocyte Esterase	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

REMARKS

(b)(6)-2

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
LLA

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

MD DATE
TECH 3Jul03

LAB. ID NO.

PATIENTS MED. RECORD

URINALYSIS
URGENCY: STAT ☐ PRE-OP ☐ TODAY ☐ ROUTINE ☐
PATIENT STATUS: BED ☐ AMB ☐ OUTPATIENT ☐ DOM ☐ NP ☐
SPECIMEN SOURCE: ROUTINE ☐ OTHER (Specify) ☐

URINALYSIS
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 201-45.505
550-107

(b)(6)-4

TEST(S)
SPECIMEN TAKEN
DATE 02Jul03 TIME 2015 A.M. P.M.
REQUESTED

RESULTS

Glucose	132
Bun	7
Na	139
K	3.5
Cl	106
TCO_2	24
AnGap	13
Hct	46
Hb	16
pH	7.367
pCO_2	40.1
HCO_3	23
BEecf	-2

Fcull2

BSAP

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

REMARKS
I Stat 8

(b)(6)-2

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

MD DATE
TECH SR 3Jul03

LAB ID NO.

PATIENT'S MED. RECORD

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

ICU 2

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

FORMS DISPLAYED ON THIS SHEET ARE (Check one)

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)

MOUNTED ON STRIPS 1, 3, 5, AND
- ☐ PARASITOLOGY (SF 552)
- ☐ IMMUNOHEMATOLOGY (SF 5
- ☐ ASSORTED FORMS
- ☐ OTHER (Specify)

MOUNTED ON STRIPS 1, 4, AND
- ☐ MICROBIOLOGY I (SF 553)
- ☐ MICROBIOLOGY II (SF 554)
- ☐ MISCELLANEOUS (SF 557)
- ☐ ASSORTED FORMS

PRESCRIBE BY GSA/ICMR
FIRMR (41-CFR) 201-45, 505

LABORATORY REPORT DISPLAY

GPO 1994

TEST(S)

SPECIMEN TAKEN

DATE 03 July 03 TIME 2015 A.M. P.M.

RESULTS	REQUESTED	(X)
4.95	RBC COUNT	
14.4	HEMOGLOBIN	
44.8%	HEMATOCRIT	
90.6	MCV	
29.1	MCH	
32.1	MCHC (X)	
10.6	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
12.6	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
157	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	
13	Lymph	

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

REMARKS: CBC

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE: (b)(6)-4

REPORTED BY: (b)(6)-2

TECH: 3 Jul 03 1028 HR

MD DATE

LAB. ID. NO.

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

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

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

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE 04 July 03 TIME A.M. P.M.

RESULTS	REQUESTED	(X)
4.97	RBC COUNT	
14.2	HEMOGLOBIN	
44.6	HEMATOCRIT	
89.8	MCV	
28.7	MCH	
31.9	MCHC	
11.4	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
13.0	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
145	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	
1.5	Ly#	

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

REMARKS: CBC

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE: (b)(6)-2

REPORTED BY: (b)(6)-2

TECH: 4 Jul 03 1238

MD DATE

LAB. ID. NO.

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

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

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

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST FIRST MI	UNIT	RANK	SSN
(b)(6)-4			

Physician:	Ward:	STAT / Routine	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	EMT		23JUL03, 0849	(b)(6)-2	0924

I STAT 8 Chemistry (I-STAT)

X	TEST	RESULT	REF. RANGE
	Na	139	128-145 mmol/L
	K	3.3	3.3-4.7 mmol/L
	Cl	106	98-108 mmol/L
	pH	7.304	7.35-7.45
	PCO2	48.5	35-45 mmHg
	PO2		80-90 mmHg
	TCO2	26	18-33 mmol/L
	HCO3	24	22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap	12	8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN	11	7-22 mg/dL
	Glu	188	73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:			
Crystals:			
Other:			

Chemistry (Piccolo Analyzer)

X	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
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		30-170 U/L
	CL		98-108 mmol/L
	TCO2		18-33 mmol/L
	Creat		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	TProtein		6.4-8.1 g/dL
	Na		128-145 mmol/L

Microbiology

Source:		
FecLeuk		Negative
Gram St		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite

Blood Bank

ABO/Rh		
T&C		
T&S		

HCG

Urine		Negative
Serum		Negative

CBC Hematology

X	TEST	RESULT	REF. RANGE
X	WBC	12.6	4.8-10.8 x10(3)/uL
	RBC	4.91	4.2-6.1 x10(6)/uL
	Hgb	14.9	12.0-18.0 g/dL
	Hct	44.7	35.0-60.0%
	MCV	91.0	80.0-99.0 fl
	MCH	30.4	27.0-31.0 pg
	MCHC	33.4	33.0-37.0 g/dL
	Plt	161	130-400 x10(3)/uL
	LY%	7.0	15.0-55.0%
Y	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Imm

RBC Morph:	
Plt verify:	
Spun Crit	35-60%

Malaria Smear

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate

Sed Rate		1hr = 0-20 mm

Coagulation

PT		10-13 seconds
APTT		22.1-33.7 seconds
FDP		Negative

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Negative

Other:

FORM BEARLAB 20 31 May 2003

519-301

NSN 7540-01-165-7294

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

C-spine, chest, pelvis

AGE | SEX: M | SSN (Sponsor): (b)(6)-4

WARD/CLINIC: EMT

REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY *(Print)*: (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR: (b)(6)-2

DATE REQUESTED: 3 July 03

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

High Speed MVA —

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

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

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

RADIOLOGIC REPORT

C-spine

- Only C_1 — C_6 - clear

Cannot see C_7

Chest No Acute Cardiopulm. ds

pelvis ⊖ H

(b)(6)-2

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

Iraq

(b)(6)-4

Civ ♂

Trauma

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 3 Jul 03 TIME OF ORDER: 0930 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU / (b)(6)-2
2. Closed head injury
3. Stable
4. Bedrest; spine precautions
5. Continuous monitor; temp q 8°
   BP/pulse q 2°
   Neuro checks q 2°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

6. IV - NS 150 cc/Hr
7. NKDA
8. NPO
9. O2 / NC PRN for sats <93%
   Notify physician if require >4 Liters
10. MSO4 2mg IV q 4° PRN pain
    Ativan 2mg q 8° PRN agitation
    Haldol 5mg IV q 8° PRN agitation

Noted 3 Jul 03 0930 hrs (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

11. Wound care: Leave dressing on for 24° unless soaked; then clean and apply bacitracin/antibiotic ointment BID to scalp lacerations
12. CBC at 1500 and I-stat 8
13. UA

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

(b)(6)-2

3 July 03

1. Physical restraints 2 point x 24 hours. Contact physician prior to release for re-eval

Noted (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

FAMILY PRACTICE

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 2 JUL 03 TIME OF ORDER: 1310 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Foley to gravity

(2) Ativan 1 to 2 mg IV Q 4 PRN

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MAJ MC

PATIENT IDENTIFICATION

DATE OF ORDER: 3 July 03 TIME OF ORDER: 1930 HOURS

(1) Give 5 mg Haldol now for agitation

V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2 noted (b)(6)-2 3 July 1930

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER: 3 July 03 TIME OF ORDER: 2314 HOURS

(1) Haldol 5-10 mg IV Q 4 PRN agitation.

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

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

4 July 03

PATIENT IDENTIFICATION

DATE OF ORDER: 4 July 03 TIME OF ORDER: 0930

(1) CBC, ETAT - 8

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

MAJ MC

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				4 July 03	1340 HOURS	
			(1)	Transfer to civilian facility as scheduled		
					(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
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 COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5
3 Jul	(b)(6)-2	Bedrest - spine precautions	06	(b)(6)-2		
			14			
			22			
3 Jul		Continuous monitor -	06			
		Resp q 8°, B/P Pul x q 2°	14			
			22			
3 Jul		Neuro ✓ q 2°	06			
			14			
			22			
3 Jul		Wound care: Bacitracin	10			
		BID to scalp lacerations	22			
3 Jul		Physical Restraints 2pt	06			
		x24° - consult physician	14			
		prior to removing	22			
3 Jul		Elev to gravity	06			
			14			
			22			
3 Jul		NPO	B			
			L			
			D			

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Closed Head Injury

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

(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 1 OCT 78 4677 — EDITION OF 1 DEC 77 MAY BE USED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 Jul	(b)(6)-2	Admit to ICU - (b)(6)-2 (stable)	3 Jul	1000	1000	(b)(6)-2
3 Jul		CBC @ 1500 hrs & I Stat 8	3 Jul	1500	2000	
3 Jul		UA	3 Jul	ASAP	2000	
4 Jul		CBC & I Stat	4 Jul	Now		

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

★ U.S. GPO:1997-418-290/55267

CAL RECORD

THERAPEUTIC DOCUMENTATION CARE

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

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

INITIALING CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5
(b)(6)-2	IV NS @ 150cc/hr	06	(b)(6)-2		
		14			
		22			
(b)(6)-2	O2 2LNC prn sats <93%	06			
	(notify physician if >4L)	14			
		22			

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Closed Head Injury

PATIENT IDENTIFICATION: (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

USAPA V1.00

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr _____

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3July	(b)(6)-2	Haldol 5mg IV now for agitation	3July	Now	1930	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
3Jul	(b)(6)-2	MSO4 2mg IVq 4° prn	1530 2mg 3July	2030 2mg 3July	2310 2mg 3July	0155 2mg	0320 2mg (b)(6)-								
		pain	(b)(6)-2												
3Jul		Ativan 2mg IVq 4°	2mg 1100	2mg 1915	0155 2mg	1040 2mg									
		pm agitation	(b)(6)-2												
3Jul		Haldol 5mg IVq 8°	5mg 1430 3July	5mg 1930 3July											
		pm agitation	(b)(6)-2												
3Jul		Haldol 5mg 10mg IVP Q4°	2315 5mg 3Jul	0100 5mg 4Jul	0515 5mg 4Jul	1005 5mg 4Jul	1040 5mg 4Jul								
		pm agitation	(b)(6)-2												

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

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

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		9 8	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—		0715	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU 2	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND (b)(3)-1 MEDICAL TREATMENT FACILITY: B CO (b)(3)-1 JH, FMS

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
2 1 Iragi Hosp		2 0 0 3 0 7 0 4

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
B I A A	(b)(3)-1	2 0 0 3 0 7 0 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
	(b)(3)-1	2 0 0 3 0 7 0 3

FOR LOCAL USE

Jy. 8721

8659

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

DA FORM 2985, MAR 2000 EDITION OF MAR 89 USAPA V1.00

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4

BenCat K78
FMP20

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER (b)(6)-2

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: D/C to care

26. DATE OF DISPOSITION: 25Sep03

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY: explosion / bomb (887.1)

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(1) Traumatic ~~[illegible]~~ below elbow amputation (L) LE 887.0 ICD9.02

(2) open (L) femur subtrochanteric fx c large soft tissue loss 820.32 ICD9.02

(3) multiple (L) LE shrapnel wounds E991.9 ICD9.02

☐ CHECK IF CONTINUED ON REVERSE

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

36. TOTAL DAYS ALL FACILITIES

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

SIGN (b)(6)-2 DICAL OFFICER

SI (b)(6)-2 EDICAL RECORDS OFFICER

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG 7

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Yo Iraqi GPW Slp injury c̄ explosive device 8/24/03
Tx'ed @ local Hospital c̄ amputation @ LE @ Forearm & PD
wounds @ hip & @ LE. Transferred for definitive management.
* C/o pain, ↓ c̄ motion & deformity @ LE

PMH — PSH — NKDA — & meds
HKP/DDD — ∅
LS Spine

PHYSICAL EXAMINATION

(PE) huge soft tissue skin loss @ hip c̄ large area exposed muscle & open @ femur fx
FHR, TA, GS, BCR, NSS — faint DP/PT pulses
good capillary refill
Traumatic amputation @ LE @ distal @ forearm level

(A): (1) Traumatic @ LE amputation @ distal forearm level
(2) open @ subtrochanteric femur fx c̄ huge soft tissue injury.

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

(P) (1) I&D all wounds
(2) Ex-Fix/limited internal Fixation @ femur.
(3) Revision @ LE amputation

SI (b)(6)-2	DATE 8/25/03	IDENTIFICATION NO.	ORGANIZATION

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

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

29 Aug 03 OP-NOTE

Pre/Post-op Dx: ① Traumatic ⓐ UE ⓑ wrist disarticulation.
② Grade III open ⓐ subtrochanteric femur fx c̄ large 20cm x 20cm skin defect.
ⓐ multiple ⓐ UE shaped wounds

Procedure: I&D ⓐ UE/ⓑ Lg/thigh
Circular amputation ⓐ UE BKA
Ex-Fix ⓐ femur c̄ limited internal fixation

Provost, Phillips, Choi
GBC 2000cc
8 comps to ICU unstable cond

(b)(6)-2

MD
RN/Nurse

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

509-114

DATE	NOTES
26 Aug 03	Anesthesia
0928	- pt. awake and alert this am. and without complaint.
	Wound (LE) not examined - defer to Dr. Prevost. Antibiotic
meds:	coverage changed today to include PCN G.
1. Ancef q8°	BP 159/81 HR 177 R 25 Sat 97% RA
2. Gent 80mg q8°	Lungs: CTA (B) Heart: nl S1, S2, ø murmurs
3. Pen G 4mu q6°	CK 1735 H/H 9/30 130 / 110 / 12 < 161; 3.8 / 26 / 0.6
3. Mannitol p'n	Imp: POD #1 following revision of LUE hand amputation,
	Ex-fix of (L) femur. Large area of exposed thigh muscle.
4. MSO4	↑SC CK and large blood in urine c̄ only 5 RBCs worrisome
	for ~~poly~~ rhabdomyolysis. Will continue to force diuresis
	⊕ c̄ mannitol and aggressively hydrate.
	(b)(6)-2 MD (b)(6)-2
27 Aug 03	Anesthesia
0744	- pt. resting comfortably this am c̄ complaints. Events of concern overnight
	include a T 101+ and a desaturation episode to 88% on RA.
	CXR shot this am - result (P).
	HR 112 BP 145/86 R 16 Sat 96% (2l NC)
	Exam: lungs: (R) basilar rales; (B) diffuse quiet exp. wheezing
	CV: nl S1, S2, ø murmurs.
	Wounds: defer to orthopedics.
	Labs: CK 685 H/H 7/22 133 / 102 / 12 < 130; 3.9 / 0.9
	Imp/plan: - CK falling - reassuring w/r to my initial concern for rhabdo.
	Will check 2 more times then D/c. D/c mannitol. Change IVF to
	D5 1/2 NS c̄ 20 KCl. Institute Albuterol neb q8°, encourage coughing, deep
	breathing. To OR today for adjustment ex. fix, washout.

L RECORD

PROGRESS NOTES

NOTES

Anesthesia addendum

CXR - difficult to interpret this suboptimal portable exam. Poor inspiratory effort / lordotic film. Some suggestion of atelectasis vs. consolidation, RML / RLL.

(b)(6)-2

SPONSOR'S NAME

LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

ATIONSHIP TO SPONSOR

RECORDS MAINTAINED AT

HOSPITAL OR MEDICAL FACILITY

PART./SERVICE

REGISTER NO.

WARD NO. ICU-2

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

509-114

MEDICAL RECORD | nursing notes

~~PROGRESS NOTES~~

~~NOTES~~

DATE

Aug 03 1500 transferred from recovery to ICU 2 (same bed). Alert, 40 pain 4/10 via interpreter, O2 sat 99% on 1L of O2 N/C, O2 decreased to RA, ∅ SOB observed, central line to (R) IJ CDI, LR infusing @ 80cc/hr, lungs clear, bowel sound active 4 quads, Foley draining clear yellow urine, edema 1+ to (R) UE, (R) LE has scabs OTA pink in color, ABD has abrasions OTA white in color, Amputation site to (L) UE CDI Ace wrap, (L) LE I pin site CDI will cont. to monitor pt (b)(6)-2

(b)(6)

7 Aug 03 1900 VSS T. 99.9. P-132. Other VSS. Urine output @ approximately 50cc/hr. Good pain control at this time. Eating grapes S difficulty. Dilaudid given at 1800. Dr (b)(6)-2 by to see pt no D's in orders. Will continue to monitor. (b)(6)-2

27 Aug 03 2130 Pt given Tylox (2) for pain. Temp ↑ 100.5. O2 Sat 70 98% RA. Penicillin given IVPB. Sleeping comfortably since last note. (b)(6)- Clear amber urine in foley. output 450 cc for 4 hours.

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	WARD NO.

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.

PROGRESS NOTES
Medical Record

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

509-114

PROGRESS NOTES

:DICAL RECORD

DATE	NOTES
	34 y/o @ c (R) arm amputation BS Before Tx
1/6 03	Coarse Rhonci throughout all lobes Sats 96% RL NC
830	HR 106 Alb SD Q8 c O2 6LPM S/p Tx
	pt Sat 96 on ~~RA~~ no 2L O2 BS improved xet
	consitant next Tx 1730 (b)(6)-2 ca7
1 Aug03	pt given SD alb via neb c 8L O2 During Tx
1630	99% Sat HR 134 BS improved c Tx Next Tx 2030 no
2030	pt given SD Alb c 10L O2 pt HR 132 Before Tx. BS s
5 Aug	Tx improved but resistant Bilat course wheezing Bases pt Sat 96% s Tx no
Aug03	0730 pt. alert, fowler position, HR 117, RR 18, SatO2 94/95 @ RA, B.BS. coarses, ↓ bases (R) side, inspiration wheezes, given HHN 0.5cc albuterol/3.0cc NSS, pt. tolerate tx. well SGT (b)(6)-2
Aug03	1530 pt. alert, semifowler position, HR 118, RR 18/19, SatO2 93/94% @ RA, BBS ↓ bases, (R) side, ~~BBS~~ sexor give HHN 0.5cc albuterol/3.0cc NSS, pt. tolerate tx. well SGT (b)(6)-2
2 Aug03	2330 pt. sleeping, HR 84/85, RR 11/12, SatO2 93/94% @ RA BBS ↓ (R) side, given HHN 0.5cc albuterol/3.0cc NSS

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	WARD NO.

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

(b)(6)-4

Egy male

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

509-114

DATE	NOTES
continue	pt. tolerate tx. well ——— SGT (b)(6)-2
29 Aug 03	0800 Pt awake and alert. HR: 111 SpO_2: 98% on RA RR: 12 BS: BBS/diminished throughout c̄ wheezing. Pt gave 0.5cc albuterol c̄ 2.5cc NSS via SVN and aerosol mask. Pt tolerated tx c̄ adverse effects ——— SGT (b)(6)-2
30 Aug 03	0100 Pt awake HR: 120 RR: 14 SpO_2: 94% on RA. BS: BBS/ diminished throughout. Pt given 0.5cc albuterol c̄ 2.5cc NSS via SVN Pt tolerated tx c̄ adverse effects ——— SGT (b)(6)-2
30AUG03	0800 pt tolerated tx well See note in other progress not SGT (b)(6)-2
	1600 pt sat 95% RR up 12 See other note SGT
	2200 pt sitting up tx given via mask well tolerated SGT (b)(6)-2
	2325 pt placed on 3L NC Sat 89% HR 119 (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Aug 03 2145	Pt sleeping comfortably. Tylox effective for pain. Good use of IS use. Notable drainage continues from operative site. PCN given. Will continue to monitor. — (b)(6)-2 LRJ
28 August 03 @ 2210	Nurse note: Patient lying supine. HOB ≈ 30° Alert and oriented. Vital: see flow sheet. Lt @ 80cc. +1 pitting edema to RUE. (R) IJ patent. pending dressing Δ LUE bandage C/D/I. Below the elbow amputation. Bandages to LLE c̄ external fixator to to thigh. (+) drainage to dressing to thigh. Abdomen distented + firm. BS ↓ BS. Lungs clear to upper lobes ↓ in lower + bases. Dressing change to LLE pending. Encouraged deep breathing and use of I/S. Will continue to monitor for Δ. — (b)(6)-2 CPTAU
28 Aug 03 @ 2300	Pt request cold water; given. Pt made aware c̄ interpreter of NPO status p̄ MW. — (b)(6)-2 CPTAU

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.

POTUS # (b)(6)-4

PROGRESS NOTES
Medical Record

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

509-114

DICAL RECORD

PROGRESS NOTES

DATE	NOTES
y03	2220 (continued) dressing gauge & tape CDT, (D) thigh external fixator bandaging CDT, LS CTA (R) radial pulse present normal BS normal active x 4 quads, abd distended/soft NAD Ø tenderness Ø pain to touch CTA abrasions to abd & legs bilaterally will continue with current plan of care (b)(6)-2
Aug. 03 530	Anesthesia procedure note - Asked to change the patient's central line 2° to kinking. Sterile prep / drape / gown / glove. Introducer exchanged over a wire for a triple lumen catheter. All lumens aspirate and flush easily, Ø complications. CXR done, shows appropriate position. (b)(6)-2
Aug 03 0415	pt resting c/o thirst PO fluids provided, V/S stable NAD, Ø changes from last assessment (b)(6)-2
AUG 03 0800	pt Resting pt given SD AIB pt BS Base wheezes pt S/P SpO2 99% 4LV20 4x BS improved pt sleeping (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.

Potus (b)(6)-4

PROGRESS NOTES
Medical Record

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

509-114

ICAL RECORD

PROGRESS NOTES

ATE	NOTES
603	pt given SD Alb via mask pt lying down
0	BS ⊖ wheezing throughout before tx
	pt Resting on RA 94% Sats HR 76
1603	pt Reclining given Alb SD via mask
200	BS Diminished pt Sats 116 HR 92 %
	Pt BS improved see pres. Stant ⊂ 7x (b)(6)-2
00	

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	WARD NO.

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

POTUS (b)(6)-4

REGISTER NO.

PROGRESS NOTES
Medical Record

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

509-114

AL RECORD

PROGRESS NOTES

NOTES

Remarks

(b)(3)-1

PRBC's

4 03	0030	116	132/70	(91)	20	100.4 @ Ax
	0035	116	135/71	(92)	18	100.2 @ Ax
	0040	116	131/69	(90)	18	100.5 @ Ax
	0120	114	129/66	(90)	20	100.2 @ Ax
	0140	114	128/74	(94)	22	99.8 @ Ax
	0240	111	124/71	(92)	20	99.2 @ Ax
	0340	109	129/78	(92)	20	99.2 @ Ax
	0440	107	126/75	(91)	18	99.6 oral
	0455	107	128/98	(93)	18	99.9 oral
4 03	0500	109	130/82	(98)	16	
	0505	109	129/82	(100)	18	98.5 @ Ax
	0535	109	132/82	(101)	16	99.2 @ ax. HOP 1100cc
	0605	see flowsheet				
	0705					
	0805					
	0905					

completion

(b)(3)-1

(b)(6)-2

4 03 0830 pt. alert, semifowler position, HR 100/101, RR 18/19, SatO2 94% @ RA, BBS CTA good air movement, given HHN 0.5cc albuterol/3.0cc NSS, pt. tolerate tx. well — SGT

(b)(6)-2

SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
RELATIONSHIP TO SPONSOR	LAST	FIRST	MI
		RECORDS MAINTAINED AT	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REGISTER NO.	WARD NO.

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

PoTus

(b)(6)-4

PROGRESS NOTES
Medical Record

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

509-114

DATE	NOTES
1 Sep 03 1330	Ortho Op Note Pre/postop Dx: (L) LE wound infection Op: (L) LE D/I washout ; (L) LE D/I washout & dress (b)(6)-2 / (b)(6)-2 (b)(6)-2 / (b)(6)-2 CRNA (b)(6)-2 Minimal purulence (L) amputation site: (L) LE debrided fibrinous tissue; friable muscle ⊘ gross necrotic tissue Blood 700 cc LR UOP 300 cc I+O EBL min ⊘ complications. Packed open. wet to Dry. ACE wraps To ICU c̄ SV, VS WNL Note: Dr (b)(6)-2 did rectal exam – ⊘ stool in vault / ⊘ impaction (b)(6)-2 (b)(6)-2 LTC Dsn

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2SEP03	Medical Nutr Therapy
0900 S	Consult for nutr support recs
O	Iraqi EPW s/p amputation m + fx, NPO since 30 Aug
	Currently NGT to suction c̄ distended abdomen (ileus)
	wt 77kg Meds noted: ancef, e-mycin, demerol
	Labs Na 144 K 3.8 gluc 197 BUN/Cr 18/.8 (2Sep)
	alb 1.4 (30 Aug) - likely 2' dilutional effects
A	Pt with ↑ nutr needs to support healing which may
	be compromised c̄ extended NPO.
	Nutr needs est-@ 1900-2300 Kcal/d (25-30 Kcal/kg)
	& 75-90 gm pro/d (1-1.2 gm/kg).
R	If able to feed enterally, use Vivonex, elemental
	formula at target rate 85cc/hr to provide 2040 kcal +
	78 gm pro/d. Initiate at 20cc/hr & adv 20cc/hr q
	6-8 hr as tolerated.
	For TPN, provide 2040 Non protein Kcal + 80 gm pro
	maximally concentrated (450 gm D50 (900cc); 80 gm
	15% aminosyn (533cc); 57 gm 20% lipid (285cc) +
	150cc electrolytes. = 79cc/hr total volume 1868cc -
	Dextrose infusion rate would be 4.0 mg/kg/min below
	max of 5. Monitor K+ Mg + PO4 for refeeding.

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR (SSN or
	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.

POTUS

(b)(6)-4

PROGRESS NOTES
Medical Record

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

509-114

DATE	NOTES
	Nutr Note continued
P	Available to assist - will follow
	(b)(6)-2 MD RD
	MAJ ISP
25 Apr 03	Gen Surg Note
1030	Following pt. to OR for ASD drainage, KUB revealed dilated colon - SB & stomach not dilated. Exam revealed distended ABD & ↓ BS. Pt. has clinical picture of ileus. After (+) arm strap was noted out yesterday, temp ↓ & WBC ↓ from 18 to 10. Pt. currently has NGT. ABD is softer & less distended than yesterday. Non-tender. ∅ peritoneal signs. Pt. currently on IV erythromycin. (+) BS. Overall, pt. has ileus, which appears to be slowly improving.
	- Rec continued NPO, IVF
	- Cont NGT
	- Cont IV erythromycin
	- will out to follow (b)(6)-2
	MAJ

09-113

NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE					
2/2/03	PRBC's # 1				
	T	P	R	BP	SAT
1229	101°(A)	110	24	103/60	95%
1235	101°(A)	110	26	105/64	95%
1240	101.3(A)	109	24	106/64	97%
1255	101°(A)	110	25	107/64	97%
1310	100.9(A)	109	24	109/66	96%
1345	100.7(A)	105	22	109/65	97%
1415	100.4(A)	102	25	106/66	96%
1445	100(A)	104	23	105/67	96%
1510	99.9(A)	100	24	116/60	97% #2 PRBC's start
1515	101.1(A)	101	26	108/63	96%
1520	99.9(A)	101	27	113/72	96%
1525	99.9(A)	99	26	112/71	96%
1550	99.5(A)	100	29	103/71	95%
1605	99.9(A)	99	25	113/72	94%
1620	100.4(A)	100	25	114/74	94%
1630	#2 unit PRBC's stopped for IV meds				
RESTART 1700	100.5(A)	98	29	112/71	94%
1705	100.7(A)	98	24	116/23	94%
1710	100.7(A)	97	27	117/72	94%
1715	100.7(A)	96	26	111/73	95%
1720	100.5(A)	98	26	110/70	95%
1745	100.9(A)	101	26	109/76	94%

(Continue on reverse side)

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

POTUS # (b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	T	P	R	BP	SAT	
1800	100.5	101	28	114/71	94%	(b)(6)-4
1830	100.4	102	26	123/72	94%, 95%	Blood complete

NSN 7540-00-634-4122

9-113

MEDICAL RECORD | PROGRESS NOTES

DATE

2 Sep 03

Orthopaedic Surgery

VSS - Temp 101.7

pt alert.

ABd soft - per GS + exam - still distended

(2) Arm dressing dry + intact

(2) Hip dressing intact

↓ HCT (22) WBC ↓ 10 (↓ fr 18)

(1) open fx to Prox Femur (3) Anemia

(2) (1) BE Amputation

(3) infection (1) BE stump

(4) Illeus

Plan: (1) ABP gentamicin

(2) TPC drains PRBC's

(3) KUB in AM

(4) ✓ Creatinine

(5) to OR tomorrow for

(1) Arm stump washout

(6) Continue BID Dressings

(b)(6)-2

3 Sep 3

Ortho Surg

- Hbg ↑ to 10; WBC - ↓ 9.3, STABLE, Belly softer.

- consent obtained → to OR this AM

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

Potus # (b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
3 Sep 03	OP Note Blast injury (L) ARM / (L) hip Same 1. I+D (L) ~~Elbow~~ Below Elbow stump site (2) I+D (L) Hip (b)(6)-2 + (b)(6)-2 GET Elbow prepped + draped - clean. No foul odor. - 3 L WASHED Through. vessel loop used to Bring edges together & pusher - (L) hip wound debrided. Foul odor from lateral side. No Abscess to palpation. - wound packed c̄ wet 4X4. - Pt. wached. Returned to ICW-1. in stable condition (b)(6)-2 MAJ
4 Sep 03	ORTho note Tmax. 99.4 Pt comfortable. WOUND SANS AROMA. Dressing Δ'd last night + this AM Hbg - 7.8 Cre - 0.8 WBC - 8.3 - Blast inj - Pi: (1) Return to OR tomorrow I+D / Elbow / hip (2) Continue Gentamicin (b)(6)-2

DATE

/Sep/03 OP Note
Blast injury - Below Elb Amp; ② open Hyp. Fx; infection
same
I&D Both sites
(b)(6)-2
Elb - mm Comp.
Pt ē ↑ superficial pus at Elbow 3L WASHED thoroughly
ē pulsavac Area by Ex Fix pins washed multiple
times ē pulsevac Dead skin debrided.
vessel loops ē rubber Bands used to Keep Flaps
pulled together. Packed ē Damp Kerlix.
- pt tolerated procedure well. To Pt in SATISFACTORY
CONDITION
(b)(6)-2

6 Sep 03 POD#1
Tmax 100.1 (Ax) pulse other VS STABLE
Pt stable Abd soft
⊕ DRAINAGE from ARM
- Continue Dressing changes
✓ Cr + K/H in AM 7 Sep 03
(b)(6)-2
- Discussed ē Dr (b)(6)-2 regarding
DIET.

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

POTUS ## (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES

DATE

7 Sept 03 POD#2

VSS Afebrile

P.O. tolerated well. Pt c/o mouth pain - specifically tongue.

ABd soft

Dressing's Dry. Wound looked good on LE Amp site

A: B E A L ARM; (L) hip Fx c̄ soft tissue defect.

P: I+D tomorrow. - Continue Dressing changes/ Arm/leg.

(b)(6)-2

MAJ (b)(6)-2

8 Sep 03 OP Note

(L) B E Amp

(L) Open Hip Fx c̄ large soft tissue defect

I+D; shortening bone (L) B E Amp.

wound Packing (L) hip

(b)(6)-2

GET -

- Radius/Ulna shortened ~ 1 cm each

- soft tissue closed around them Rubber band technique used to close wound. wet to dry packing used. Skin edges freshened.

(L) hip probed. small area of open packed c̄ packing "1/2".

- tolerated procedure well.

(b)(6)-2

MAJ (b)(6)-2

(Continue on reverse side)

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

POTUS# (b)(6)-4

REGISTER NO. ARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

DICAL RECORD

PROGRESS NOTES

TE

203 POH#1

VS Thru 103

pt not taking much orally.

- Abd soft. wound packing proceeding well.

No foul odor. Arm or leg. ↑ Crea 1.5 (90.8)

will ✓ CXR; ↓ Cent Line, + Urine.

Nutrition ~~eval~~ eval.

(b)(6)-2

Sep03 PT note:

10hrs. pt. A&O x3, sitting in chair @ bedside — c̄ (D) LE propped @ ~90° hip flexion (on chair). pt. able to perform AROM c̄ ankle — restricted (~10°) DF pt. encouraged to ROM (D) ankle. AAROM / PROM can achieve full ROM DF. Inv./Eversion WNL / PF WNL. can wiggle toes. Instructed pt. (thru interpreter) that he needs to perform ankle ROM x 4 planes (90° DF) of hour 10x each direction & wiggle toes. night splint. (to stretch achilles) / can perform achilles stretch (c̄ assistance) 5x throughout day. Dr. asked therapist to instruct pt. in Quad sets. — therapist will return to instruct in further exercises as pt. is in supine / easier to perform quad sets in supine. (b)(6)-2 MPT/SSG/91WM9.

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-00-634-4122

MEDICAL RECORD — PROGRESS NOTES

DATE

Sep 03 OP Note

BE Amp / left open Hip Fx

Same

Ex D (2) BE Amp stumps; wound dehisc A-(2) hip

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

Ans – GET

EBL min

Tourn ø Compl

2L taken through (2) BE Amp stumps. Healthy granulation tissue under suture layer. Bodies covered – Ulna not covered.

– Hip wound with good granulation tissue.

– Refer to OR 2 days

(b)(6)-2

Maj

13SEP03 Nutrition

Calorie count results for 12SEP03: ~1660 Kcal; 65 gm protein. Nursing reports ↑ appetite; currently NPO. Needs previously estimated @ ~2200 kcal + 75-100 gm pro/d. Labs alb 1.5 ↓ – as expected c̄ fluids / open wound.

R/ If feeding tube is placed, consider Vivonex – elemental

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PotUS (b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
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PROGRESS NOTES

DATE

Nutrition continued.

formula to start. Can transition to Jevity or Ensure later. Initiate at 20cc/hr and advance as tolerated to goal rate of 85cc/hr. Monitor K Mg Pos for refeeding.

② If oral intake continues order for Ensure to Carnation Instant Breakfast. Pt not drinking ensure but will drink milk. CIB will provide additional 5gm pro + 130kcal per pkt.

③ Will follow

(b)(6)-2

MS RD

1660Kcal 71-106

NSN 7540-00-634-4122

PROGRESS NOTES

DICAL RECORD

E

Cal Count

'Kcal

Breakfast

/150cal 1 carton milk (half cream white) 250cc

/100 3/4 doughnut

/20 2 bites pancake

60 1 carton OJ

Snack

/150 1 cup milk from family

0 100cc water

Lunch

5/500 2 4-5 inch lamb cabob (~ 5 oz)

3/80 1 round bread

0/25 1/2 cup vegetables (olives, cucumbers, onions)

0/100 3/4 can pepsi

Snack

8/150 Milk half-cream white ~~1/4~~ 250 cc

0/25 1/4 can pepsi

Dinner - pepsi 150 coke 150

(Continue on reverse side)

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REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
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DATE

PROGRESS NOTES

(Dinner)

NOTE
12 Sep 03

Coke x 1
Pepsi x 1

NSN 7540-00-634-4122

PROGRESS NOTES

RD

L.M. Consult
Asked to see pt. D/T recurrent fevers
to 104 on 11 Sep x 101-102 (A)
since 3-4 7/6 Dragsi D/T detained,
sustaining below-the-elbow (R) ampu-
tation of (L) open subtrochanteric femur
fx x large open soft tissue
defect from (R) hip to (L) knee
c ex-fix in place. (-) UTI on
UTI Sx. ABX recently d/c
from Arcef, Bactrim, x gen x 1
Levaquin & cont. of gent.
PE: T: 101.4° (A) 100.9° (A) HR 124 BP 127/75 -
93% RA. Nonfoc x in traction.
ENT & (-) LAD L-CTA
RRR (tachy) (-) MOG AB distended,
(+) BS, soft, (-) M, T, or HSM. Wounds
not inflamed. (-) calf tenderness or
cords - 4 x 6 cm blood blister on
lateral aspect (L) foot.
Malaria smears (-) x 3
4/4 (9 Sep) ? abs. mod. back,
& (-) LE x intact.

9.9
8.4 26
567k

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

POTUS

DATE 15 Apr 03

PROGRESS NOTES

1423 cont

Cr 0.8
alb 1.5
Ca 8.4 (corrected) Po 4
Portable CXR ⊖ infiltrate, mottling artifact
A & Tech:
#1 - Continued fever & clear LUE stump
& healing open wound of ⓡ
hip / thigh - diff dx includes:
wound infection vs. diff dx of underlying
vs. UTI cloak pneumonia cloak
associated colitis cloak vs. antibiotic
(no evidence) vs. SBE (no evidence)
vs. osteo vs. drug fever (fevers
fever, but persist & fever (fevers
- re CXR, U/A, & ✓ ESR & ATB:)
#2 - ↓ alb & calorie & prot mal-
nutrition ↑ dietitian consult
& Carnation Instant Breakfast
req. & supplements diet
#3 - Total Ca 4 slightly ↑ d/t, when
correct for ↓ alb. Probably ↓ PT
disease. Good diuresis & fluids
Agree & present ATB coverage
Will monitor

(b)(6)-2

(b)(6)-2

Lieutenant Colonel, [redacted] MD
Chief, Department of Medicine

*U.S. Government Printing Office: 1998 - 404-763/20101

NSN 7540-00-634-4122

PROGRESS NOTES

RD

restraints loosened on (R) arm and reapplied. (R) arm [redacted] (b)(6)-2

only extremity restrained @ this time-

report on pt - assumed care. Pt agitated/redirected c̄ soft restraints (R) UE.

vital pulse (+), CR < 3 sec. NGT c̄ initial 60cc Ensure/H2O feeding complete -

monitor for s/s of complication. Dressings to (L) LE / (L) ULE c/o/i - @ this time. (b)(6)-2

Haldol 5mg iv per prior shift - monitor effectiveness.

Spoke c̄ interpreter: Stated that Pt is calling staff members by diag. names - and (b)(6)-2

is not oriented to place or time - cont. monitor. (b)(6)-2 LPN.

5mg Ambien per NG - monitor effect.

60 cc. Ensure ↑ per NG - monitor ~~effectiveness~~ effectiveness / for s/s of complication - (R)

5mg Ambien per NG repeated 2° continually crying out - restlessness. Restraint

(R) UE intact, circulation unimpaired - has been released occasionally. (b)(6)-2 LPN.

Cont. monitor.

Pt relaxed, well-medicated/sedated - Ambien effective. Pt. c̄ gross episode of

urinary incont. full linen change - Pt. OOB to chair for Δ. Dressings (b)(6)-2 LPN.

to (L) LE soaked c̄ urine. ∴ Dress. Δ'd. Soft restraint placed back

on (R) LE. Cont. monitor.

(Continue on reverse side)

WARD NO.

REGISTER NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-00-634-4122

PROGRESS NOTES

ORD

He agitated, yelling repeatedly, he appears disoriented & hallucinating. Per interpreter calling female nurse this daughter & dead at car, etc. He was given 5 mg IV Haldol @ 2200 w/ improvement. Pt has repeatedly attempted to remove pt & I long discussions w/ him, through interpreter.

A+P:
ICU psychosis (i.e. delirium) w/ improvement w/ Haldol. Will order Ambien 5 mg & assist w/ pt refusing to sleeping. This will be essential for his recovery.

(b)(6)-4

LTC 1C

03 OCTHx note
Temp Max 101 Ax; slight tachycardia
Dressing changes done tolerated NG feedings.
- TRIES to pull out NG tube.
Abd soft. Pt c̄ psychosis present
- H/H 7.7, K+ 2.4
A: ① ABE Amp, Open hip fx c̄ infection
② ↓K+, ~~↓T. AR~~ ↓ PTB. ↓ H/H
P: ① Transfuse 2 units PRBCs, gm K+, Re ✓ labs

(Continue on reverse side)

WARD NO.

REGISTER NO.

PROGRESS NOTES

Medical Record

T'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

POTUS #

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

DATE

PROGRESS NOTES

14 Sep 03 ORTHO

Discussed c̄ Pt - consider covering acute bacter.
Will START unasyn 3.0 gm IV q 6h

(b)(6)-2

15 Sep 03 OP Note

@ 6 E Amp

Afebrile Gen Pt.

- I&O all areas
- Graphic Dressings
- Gait EBL - min

Findings - Abscess @ Foreum ; + Purulence on Exam
- sent to Neuro ICU satisfactory Condition

(b)(6)-2

NSN 7540-00-634-4122

PROGRESS NOTES

:ORD

(b)(6)-4

	BP	O2 SAT	HR	TEMP	RESP	
	Blood transfusion					
	2/65	93%	105	100.3	22	Blood start #1 unit
	02/68	97%	103	100.6	22	
	10/74	94%	98	100.6	21	
	12/67	92%	99	100.7	21	
	13/73	94%	97	100.8	19	
	17/74	95%	110	100.5	22	
	109/72	93%	117	100.1	24	
	111/64	95%	119	100.0	25	
	108/71	93%	113	100.5	27	
	115/78	94%	113	99.8	24	
	109/65	94%	111	100.0	20	
	116/72	95%	104	100.2	26	#1 complete
	123/76	94%	99	99.3	24	#2 unit started
	113/75	97%	111	99.0	24	
	114/80	95%	101	99.3	24	
	100/69	96%	106	99.6	25	
1830	139/78	95%	110	99.8	22	
1845	121/75	96%	100	100.2	23	
1900	119/79	93%	104	100.0	23	
1915	116/75	93%	106	101.2	22	1gm Tylenol PO
1945	115/79	94%	109	101.5	24	
2015	111/69	95%	115	101.9	25	#2 unit complete
2045						

(b)(6)-4

(Continue on reverse side)

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

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

(b)(6)-4

Potus

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-00-634-4122

PROGRESS NOTES

ECORD

Nutrition
Nursing reports pt tolerating TF. Per nursing notes, pt eating small amounts at meals. This am - drank apple juice + ate roll.
Diet: regular c̄ 1 can Ensure q 6°
Pt actually receiving Ensure Plus ~~6~~ 4 pts cans/d = 1440 Kcal + 52 gm pro. in addition to cal/pro in oral regular diet. Needs previously estimated @ 2200 Kcal + 75-100 gm pro/d.
Labs alb 1.4 (14 Sep) & K 3.6 (16 Sep)
Alb will not respond to refeeding x 21 days
R/P ① May want to increase 1 can q 4° to provide greater portion of pro/cal needs.
② change order to Ensure plus please
③ will follow + m̄ intake oral intake

(b)(6)-2

MS, RD

Ortho
VSS - Tmax 101.7
Tolerated dressing change on left thigh c̄ discomfort.
① Afebrile, pacing - still painful - No fevers/chills
A: ① ② GE Amp
② ③ Oper for Rx
P: ① Δ to Cron Plus ② Δ sleep ③ Zyprexa

(b)(6)-2

(continue on reverse side)

WARD NO.

REGISTER NO.

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

PROGRESS NOTES
Medical Record

POTUS (b)(6)-4

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

DATE

PROGRESS NOTES

19Sep03 OP Note

A & Amp; Olec Rem Lt

Same

I&D Arm c loose closure Dressing change left Leg

Cmplte

GET EBL min

Findings & Abnes

Sent to PR in SATISFACTORY condition

(b)(6)-2

22Sep03 Nutrtion - follow up

S Nursing reports pt eating very little - state prefers Pepsi to anything else. Interpreter brought in local cuisine. Pt consumed ~300 cal, 10gm pro in bread/chux/pepsi. Pt c/o feeling full 2/ tube feeding

O Labs 9/22 gluc 305 K 3.1 BUN/Cr 15/1.1

A Diet Ensure Plus via NGT 2cans q 6hr + Regular diet

A Pt receiving 2880 Kcal + 100gm pro via tube - additional Kcal c̄ oral diet. Appears to be meeting estimated needs, however decubitis suggestive of inadequate pro intake

R/ Continue ensure plus 8 cans/d. Will monitor oral intake

P via cal ct & stress importance of [illegible] teaching

(b)(6)-2

MS, RD

MAJ, 18

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

NSN 7540-00-634-4122

PROGRESS NOTES

RECORD

3 L.M.

Urinary frequency.
UPR 250 glu, large bl, + 300 prot,
20 + WBC
Random glu 305

A+P:

#1 - Dig. hyperglycemia 2° underlying infection (?? DM) + on Cranial Flux. It also like sodas. This may sig. development of diabetes.
- Treat oral sulfonylurea. Sometimes 2° the degree of hyperglycemia, insulin is required if control blood sugar
- follow FBS

#2 - Uncertain of cause of proteinuria, but microhematuria may be from trauma related 2° Foley, recently removed. Monitor.

(b)(6)-2
(b)(6)-2 [redacted] Medical Corps
[redacted] Lieutenant Colonel
Chief, Department of Medicine

22Sep03 Ortho
Ha been afebrile x24°.
- granulation tissue on surface very clean no obvious abscess around femur. Bone exposed c̄ packing. AEM
c̄ Abscess packing going well. D glu / Blood cx
urine / (Continue on reverse side)

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO.

PROGRESS NOTES
Medical Record

- Ton note seen Mon (b)(6)-2

(b)(6)-4

Pot US

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

DATE

23 Sep 03

1501

PROGRESS NOTES

C.M.

H. ∂ delirium w/ confusion, hallucinations, insomnia, + incoherent.

FBS 221 U/A 108 mg % glu, large bl. ∂ 10-15 RBC, ⊖ nitrite + LE

A+P:

#1 - Discussed delirium c̄ Ms. (b)(6)-2 + started Haldol yesterday, @ this rec. pt sleep better - monitor + ↑ Haldol, if necessary glucagon if FBS ↑ 180

#2 - Hyperglycemia improved - monitor + ↑

#3 - Urinary incont. a/b/t DM + #1 + osmotic diuresis 2° #2. Attempting bladder + ds post - void residual. No evidence of infection

#4 - Persistent ↓ K+, prob. 2° diet - Augment ∂ p.o. KCl

#5 - Grade II sacral decubitus - poor nutrition, impaired mobility + hyperglycemia, will monitor [illegible]

(b)(6)-2

Chief, Department of Medicine

NSN 7540-00-634-4122

PROGRESS NOTES

ECORD

changed pt's dressing, pt tolerated, VS stable temp 100.4 no action taken c this time. Changed chux beneath pt c assistance. Assessment complete — (b)(6)-2 [redacted]

(0300) UPC BS, interpreter CBS

(0520) pt urinated in cup for U/A, Alert, slept poorly through night, continues to incoher person, talking to himself, breathing regular c difficulty (b)(6)-2 [redacted]

03 0615 - Assumed pt care. Pt A&OX3 c c/o pain in (L) LE. DRSG's to (L) amputation of upper ext & (L) LE CDI. (L) HH IV in (L) medial ankle patent & flushes easily. NG tube placement assessed. Pt incontinent x1. Will continue to monitor. (b)(6)-2 [redacted]

p03 0845 - D'd Drsg to (L) LE and pt tolerated procedure well. (b)(6)-2 [redacted]

03 1400 Assumed care. Pt sitting in bed c c/o of this time. Will continue to monitor (b)(6)-2 [redacted]

1500 Assisted pt OOB TC. Assisted c personal hygiene. Will continue to monitor (b)(6)-2 [redacted]

1730 Assisted pt back to bed p dinner. Pt ate ~ 40%. Pt now sleeping. Will continue to monitor (b)(6)-2 [redacted]

2200 resting @ this time. S/S of distress will cont to monitor pt (b)(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

AUTHORIZED

CHRONOLOGICAL RECORD OF MEDICAL CARE

CORD

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

1950 34 y/o ♂ to (b)(3)-1 via FLA litter - 5p blast injury. Open fx (L) femur & amputation of (L) forearm
NCO accompanying pt reports pt was wearing a back pack c̄ an explosive in it. Transferred
from Iraqi hospital. On arrival, pt dssg dry & intact. Foley c̄ 350cc urine output.
18g IV started in (R) FA running NS bolus. 1gm Ancef given. Surgeon @ BS.
1990 Pt to XR. - urine dk amber, clear. Incident occurred yesterday. See SF 558.
(b)(6)-2 /sm.
Pt to go to OR after xrays.

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

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

POTUS (b)(6)-4 PW)

000

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

(See Instructions on Back of this Sheet)

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 21CSH- Mosul, Iraq

LOG NUMBER

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ARRIVAL — DATE: 03 (YR.) TIME: 1900

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Tetanus immunization and other data): Voltarine Injections, PCN, Tylox

ALLERGIES: Ø

HOME TELE. NO. (Inc. area code):

HOME ADDRESS OR DUTY STATION (City, State and ZIP Code):

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

SEX: M AGE: 34

TIME SEEN BY PROVIDER: 1903

COMPLAINT(S) (Include symptom(s), duration): (L) arm partial amputation, blast, multiple injuries

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up):

34 y/o Iraqi male EPW received from Mosul Hospital. Was wearing a backpack with an explosive in it yesterday. The explosive detonated. (L) arm partial amputee (b)(6)-2

PMHx: "Disc prolapse in back"

PSHx: Ø

Last meal: Today 1200hrs

VITAL SIGNS: 1905 / 25 / 130 / 22 / 101.3(O) / 95%

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

ORDERS	INITS.	TIME
IV LR	(b)(6)-2	1935
stat 6 CR		1935
		1935
IGM		1940

ASSESSMENT/DIAGNOSIS: (1) femur fx c̄ massive soft-tissue degloving; (2) forearm amputation; rhabdomyolysis

DISPOSITION (Check all that apply): ☐ HOME ☐ FULL DUTY

QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic):

☐ EMERGENCY ☐ TODAY ☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE: OR → ICU

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 2020

S: as above

Blast injury 24 hrs ago.

Tx'd @ Iraqi facility

ID'd injuries: (L) femur fx, (L) arm/forearm amputation, (L) thigh ST injury, (L) tib fib, (B) feet

(4) MFW MFWS. - (B) feet (L) tib fib

C - Alert, GCS 15. Airway intact

CV - tachy

lungs - (B) CTA

abd - S/NT ¢ guarding

GU - ¢ several trauma, penis c̄ abrasions

(+) foul odor

(L) femur - massive st degloving of thigh c̄ exposure of quad

Thread PP - 2+ pulse. Moves foot

(L) forearm - wrist disarticulation

UA: large blood 1.030

13 / 98 / 222 / 29

127 | 104 | 18 | 23 | 4.0 | 21 | 9.9

CK 1305

XR

(1) (B) wrist/forearm - traumatic amp @ wrist (+) FB

(2) (L) femur - comm midshaft fx.

(3) tib fib - MF ¢ fx

(4) (B) feet - multi small frags ¢ fx.

(5) pelvis - ¢ fx (+) penile FB

abd: S/NT/ND, burns to lower abd, pelvis - stable, back - atraumatic

(CONTINUE ON SF 507, IF NEEDED)

SIGNATURE OF PROVIDER AND ID STAMP: (b)(6)-2 MAJ, MC

INSTRUCTIONS (Limitations and follow-up plans): To OR c̄ ortho. IV fluids given - 2L NS. HR ↓ to 110's

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

EPW

(b)(6)-4

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-82)

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 34
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I&D @ LUE = Ex Fix
I&D @ upper extremity = revision amputation

Medical Hx: 0

5. ADDITIONAL INFORMATION:
NPO since ADON
ROM/Musculoskeletal Limited LUE
Skin Appearance WAD

Hardware/ Prosthesis 0
Significant Other Waiting 0
Psychological/LOC Alert
Language/Cultural Iraq

Lab ✓
H&P ✓
UHCG N/A
Consent ✓

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ___ Potential for anxiety related to o Procedure o Body Image o Family Separation o Surgical Outcome o Other	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture. o Demonstrates age specific coping mechanisms	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 o Sedation o Existing Pulmonary Problems	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 ___ o Immobilization o Prep Solution o Tourniquet o ESU o Positioning o SCD	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. o Select appropriate size ESU pad

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

IRAQI (b)(6)-4

DA FORM 5179, JUN 91 Previoius editions are obsolete. FH MDA OP 176 USAPA V1.0
1 May 00 (Revised)

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to o Positioning o Tourniquet o Preexisting CV Problems	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 o Transfer o Positioning E.2. ✓ Potential discomfort due to o Positioning	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 Sld o Contacts o Glasses F.2. ✓ Potential for decreased communictaion due to Sld o Language o Hearing Aids 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 the 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. o Potential for Loss of Body Heat	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. o Maintain Body Temperature	OTHER NURSING INTERVENTIONS. Or continuation of above interventions. o Increase Room Temp (pts. 65years & older) o Maintain Room Temp between 74-81 degrees for pediatric pts. o Provide Warm Sheets/Fluids o Assist with applying bear hugger, as needed.

10. (b)(6)-2

/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

Maj/a 25 Aug 03 DATE

11.

o Patient goals and outcomes were met
o Prep solutions removed
o ESU site:
o Prep site:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

(b)(6)-2 Maj/a

DATE: 25 Aug 03 TIME: 1930

13. POSTOPERATIVE EVALUATION PREPARED BY

(b)(6)-2

DATE: 25 Aug 03 TIME: USE DA 2389

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

INTRAOPERA

MEDICAL RECORD

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

1. TRANSPORTED TO OPERATING ROOM BY (b)(6)-2 TIME PATIENT ARRIVED IN SUITE

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 Maj/AN

3. PATIENT IN ROOM / TIME NUMBER 7

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj	RELIEF CIRCULATOR	

POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Beanbag for positioning axillary roll @ axilla, pillow @ arm

B6-2

8. SKIN PREPARATION

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

SITE: @ leg from toes to groin BY WHOM: [redacted]

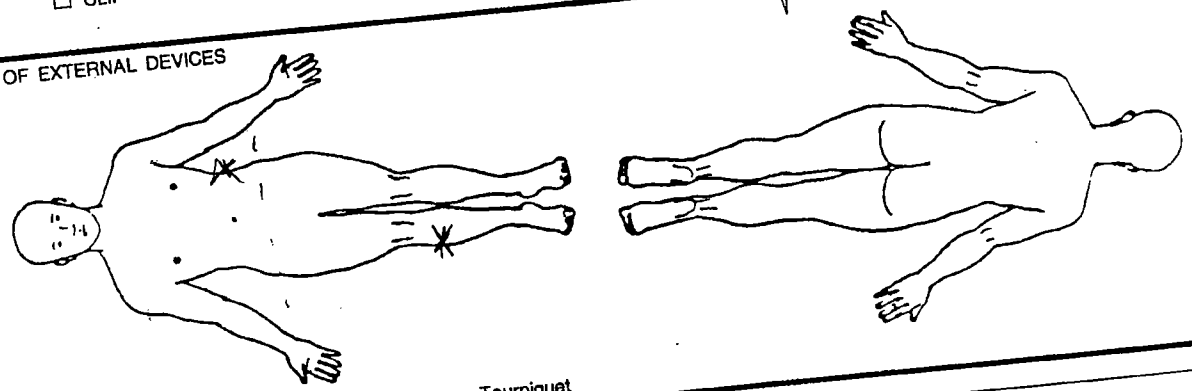
SITE: @ arm

COMMENTS: no pooling or irritation

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

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No			
Needle Sharp	☒ Yes	☐ No			
Instrument	☒ Yes	☐ No			
Other	☐ Yes	☒ No			

SCRUB (b)(6)-2 CIRCULATOR (b)(6)-2

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

IRAQI (b)(6)-4

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

☒ ESU NO: ValleyLab FX 000434

GROUND PAD: BRAND ValleyLab E7507 LOT NO: 7611 8006

☒ ESU NO: ValleyLab FX

GROUND PAD: BRAND ValleyLab E7507 LOT NO: 20010

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO

IF YES NAME: ID NUMBER; MANUFACTURER

Lot # 0123003
34 x 2
36 x 1 7 Screws
Leg Fragset

14.

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

MEDICATIONS/ORDERS

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS
Foley cath in place on arrival

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16.

LABORATORY SPECIMENS

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

TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1.	2.	3.
TE	1. Foley	2.	3.
	1. Bader	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
arm
4x8s
Abd
~~Ace wrap~~ Kerlex
~~leg~~ 4x8s
Abd
~~Ace wrap~~ Kerlex
leg Kerlex
Ace wrap

ADDITIONAL INFORMATION
(b)(6)-2
(b)(6)-2
(b)(6)-2

ERATION(S) PERFORMED
I&D L arm = revision amputation
I&D L femur = ex fix

IENT TRANSFERRED TO
ICU
ISTERED NURSE (b)(6)-2 TIME 530 METHOD litter = safety strap

E OF DA

MEDCOM - 1290

INTRAOP...

MEDICAL RECORD

For use of this form, see AR 40-407, the proponent agency is the ... REVIEWED AND PROCEDURE

T TRANSPORTED TO OPERATING ROOM BY anesthesia
TIME PATIENT ARRIVED IN SUITE

2. PATIENT ... VERIFIED BY (b)(6)-2 MyAN
4. PATIENT ... NUMBER B
TIME

Aug 03

5. PREOPERATIVE EMOTIONAL STATUS

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

NTS: Alert

6. NURSING PERSONNEL

SIGNED RUB	Spe- (b)(6)-2	RELIEF SCRUB	
	Spe		
SSIGNED IRCULATOR	May	RELIEF CIRCULATOR	
	My		

OSITION AND POSITIONAL AIDS (Specify) Positioned on padded beanbag. Warm roll @ ankle positioned on padded May stand. Spec ... LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE

MMENTS: portion

8. SKIN PREPARATION

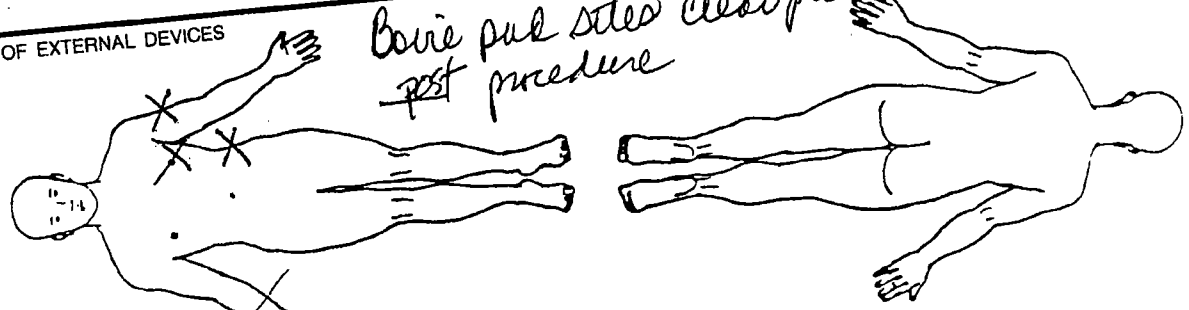
PREP SOLUTION (Specify) Betadine Scrub/solution BY WHOM: May [redacted] B6-2
SITE: (R) arm. BY WHOM: May [redacted]
SITE: (R) leg - surgeon
COMMENTS: No pooling noted

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

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES

Bare pad sites clean pre post procedure



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

10. COUNTS		C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☑ Yes ☐ No			C	Spe	
Needle Sharp	☑ Yes ☐ No			C		
Instrument	☐ Yes ☑ No				Spe	
Other	☐ Yes ☑ No					

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

Inpt (b)(6)-4

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

☐ ESU NO: Valleylab 000434
GROUND PAD: BRAND Valleylab 75071
LOT NO: exp 06May

☑ ESU NO: Valleylab 8000
GROUND PAD: BRAND Valleylab 75071
LOT NO: exp 06May

☐ BIPOLAR NO:

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

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

OSIF Screws

36 Screws LLE

14.

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

ONS

OTHER ORDERS

	TIME	CARRIED OUT BY
PHYSICIAN'S SIGNATURE		

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

16.

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

TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1.	2.	3.
18 1/2 in	portion prior to adm		
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

4x8s, kerlix, ace } LUE

4x8s LLE

abds x4

kerlix

ace

ADDITIONAL INFORMATION

Unknown allergy status

(b)(6)-2

SURGEONS-

OPERATION(S) PERFORMED

I.D LUE/LLE, Revision Stump amputation LUE

Positioning LLE Ex Fix; Pinning LLE

PATIENT TRANSFERRED TO

	TIME	METHOD
		litter EO

(b)(6)-2

MedCom - 1292

INTRAOPERATIVE

MEDICAL RECORD

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

1. TRANSPORTED TO OPERATING ROOM (b)(6)-2 BY (b)(6)-2 TIME PATIENT ARRIVED IN SUITE 0850

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

4. PATIENT IN ROOM TIME 0850 NUMBER 1

DATE 29/73

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC	(b)(6)-2 top	RELIEF SCRUB	
	SPC	Bottom		
ASSIGNED CIRCULATOR	CPT		RELIEF CIRCULATOR	
	MAJ	(b)(6)-2		

POSITION AND POSITIONAL AIDS (Specify) LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE

COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL DONE BY: ☐ YES ☒ NO ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: Ø

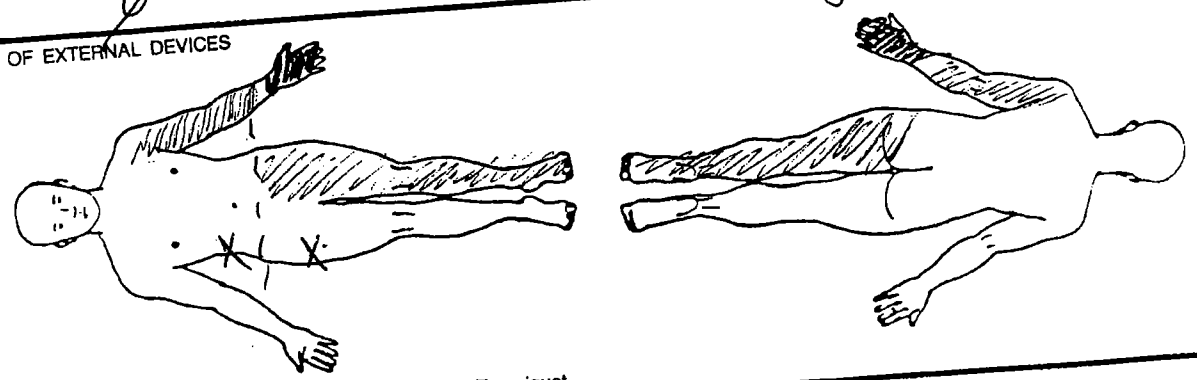
PREP SOLUTION (Specify) Betadine 5% BY WHOM: MAJ (b)(6)-2

SITE: LUE BY WHOM: CPT (b)(6)-2

SITE: LLE

COMMENTS: no grossing of sol

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ≡≡≡ Tourniquet

10. COUNTS

C = Correct I = Incorrect

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

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

Jogi (b)(6)-4

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

☒ ESU NO: 000434 Valleylab

GROUND PAD: BRAND LOT NO: 75011 30/30

☒ ESU NO: 000425 Valleylab

GROUND PAD: BRAND LOT NO: 68536 / 30/30

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): LLE x 3L4 LLE x 3L4.

OTHER ORDERS

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Penrose	2.	3.
SITE	1. LLE	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
LLE - xeroform, Coban, fluffs, Kerlix
LLE - xeroform, ABD's, Kerlix

9. ADDITIONAL INFORMATION

Dr. (b)(6)-2 - lower ext (L)

Dr. (b)(6)-2

Dr. (b)(6)-2 - upper ext (U)

OPERATION(S) PERFORMED
LLE stump revision
I & D LLE

PATIENT TRANSFERRED TO Ward TIME 1530 METHOD Primary

REGISTERED NURSE SIGNATURE (b)(6)-2 — CRT/A

ERSE OF DA FORM 5179, 1 OCT

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA LITTER BY MAT (b)(6)-2

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

3. DATE 1 SEPT 07 TIME PATIENT ARRIVED IN SUITE 1700

4. PATIENT IN ROOM TIME 1700 NUMBER 21

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: PT INFORMED THRU TRANSLATOR, PT ON NARC;

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: ALL BONY AREAS PADDED

8. SKIN PREPARATION

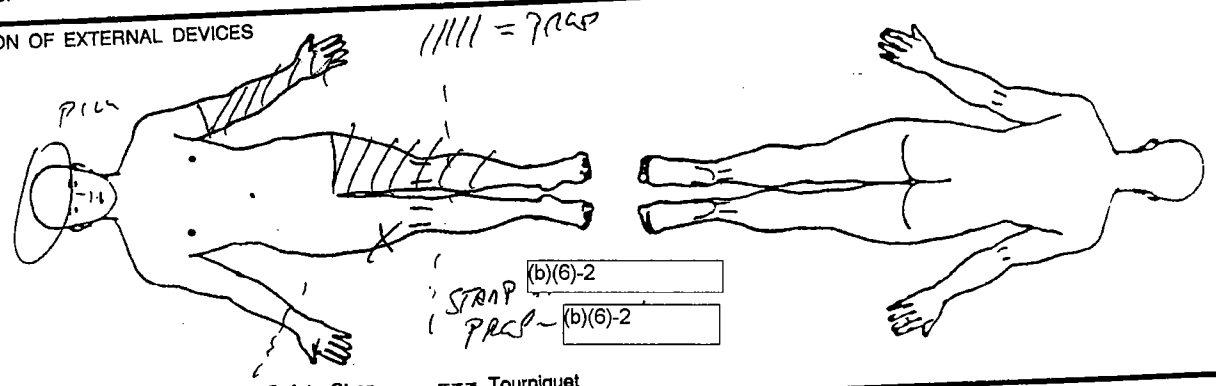
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) BETA / BETA
SITE: (C) ARM BY WHOM: MAT (b)(6)-2
SITE: (L) LEG BY WHOM: MAT

COMMENTS: NO BOOLINE OR REACHER

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No			C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No			C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

IRAQI (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 40/40

☒ ESU NO: FOC 000434
GROUND PAD: BRAND Valleylab
LOT NO: 70011

☐ 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.

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): N.S. JCR P/LAVAGE

OTHER ORDERS IN Foley CATH = 250 cc

	TIME	CARRIED OUT BY
	EOC	(b)(6)-2

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
ARM = KERLIX, 4x8, ACE
LEG = KERLIX, 4x8, ACE

19. ADDITIONAL INFORMATION
SURGEON = (b)(6)-2
WC = IV CONTAMINATED

20. OPERATION(S) PERFORMED
IRD of (L) ARM & LEG

21. PATIENT TRANSFERRED TO ICU TIME 1700 METHOD LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY Cpt (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED, AND PROCEDURE VERIFIED BY (b)(6)-2 Mg A

3. DATE 03 Sept 03 TIME PATIENT ARRIVED IN SUITE 0900

4. PATIENT IN ROOM TIME 0900 NUMBER 0900 (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj		RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Dam on < 90° padded armboard. Dam on double armboards. Safety strap over abd

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine Scrub/Sol

SITE: (L) Stump BY WHOM: Mj (b)(6)-2

SITE: BY WHOM:

COMMENTS: no pooling noted

9. LOCATION OF EXTERNAL DEVICES

Bovie pad site clean pre / ~~post~~ procedure

LEGEND X Ground Pad – Safety Strap === Tourniquet

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☑ No					
Needle Sharp	☐ Yes ☑ No					
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

IRAQI (b)(6)-4

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

☑ ESU NO: Valleylab 00433

GROUND PAD: BRAND Valleylab LOT NO: P08742 exp 05/06

☐ 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.

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

helix fluffs ace } L arm fluffs } leg

19. ADDITIONAL INFORMATION

unknown allergy status

(b)(6)-2

20

I.D (L) Stump: Debridement (D) thigh

21. PATIENT TRANSFERRED TO ICU #1 TIME 0950 METHOD litter

22. (b)(6)-2

MEDCOM - 1298

REVERSE OF DA FORM 5179-1, OCT

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Crosthem

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

3. DATE 9/5/03 TIME PATIENT ARRIVED IN SUITE 1545

4. PATIENT IN ROOM TIME 1545 NUMBER 4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: Ø

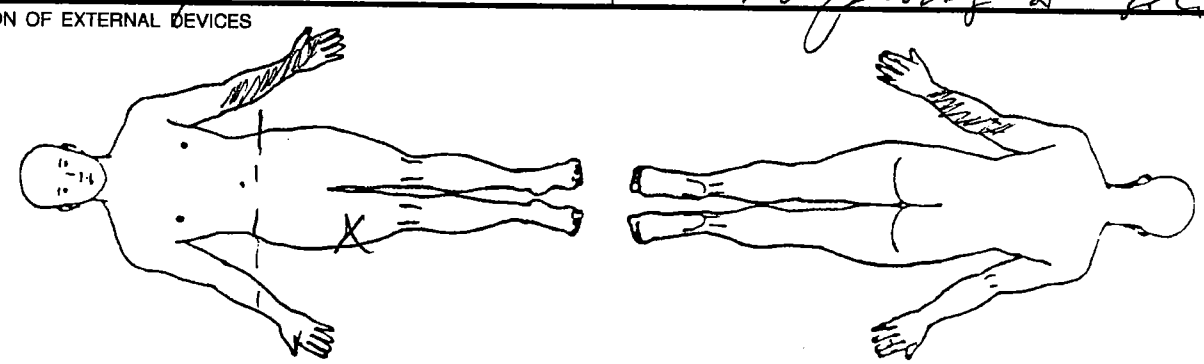
PREP SOLUTION *(Specify)* Betadine STT

SITE: LLE BY WHOM: SSG (b)(6)-2

SITE: BY WHOM:

COMMENTS: no grafting of skin

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	SPC (b)(6)-2	CPT (b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C	SPC	CPT
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

Iraqi (b)(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 REPLACE FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE

13. PROSTHESIS, IMPLANTS ☐ YES ☒ IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

(L) Ulc x 3 Lt. (L) thigh x 3 Hr

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

(L) Ulc - fluff, kerlix, ace

(L) thigh - kerlix

19. ADDITIONAL INFORMATION

Dr

(b)(6)-2

20. OPERATION(S) PERFORMED

I+D (L) Ulc + (L) thigh

21. PATIENT TRANSFERRED TO Tan | TIME | METHOD Gurney

22. REGISTERED NURSE SIGNATURE (b)(6)-2 CPT, AN

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITER BY CPT (b)(6)-2

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY (b)(6)-2 RJ

3. DATE 8 SEPT 03 TIME PATIENT ARRIVED IN SUITE 1040

4. PATIENT IN ROOM TIME 1040 NUMBER 8 AR

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: TRANSLATOR EXPLAINED PROCEDURE TO PT.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

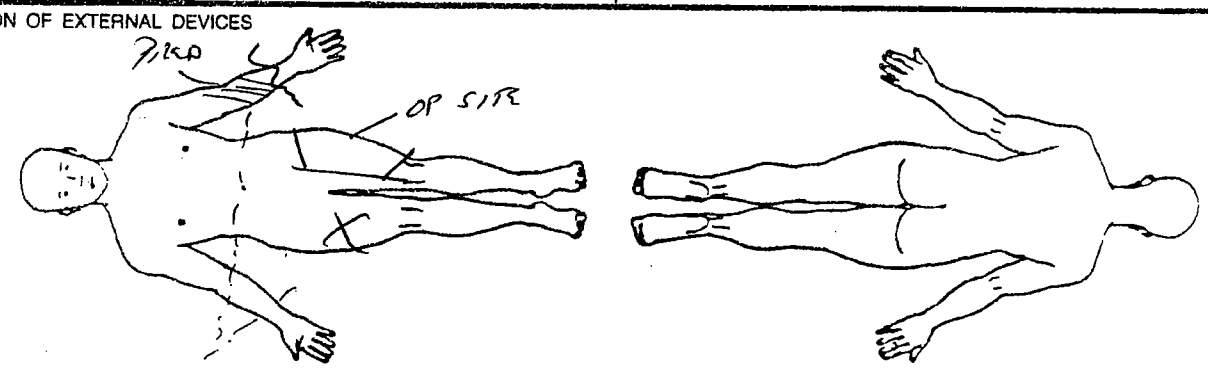
COMMENTS: ALL BONY AREAS PADDED

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* BETA / BETA
SITE: (L) ARM BY WHOM: MAJ [redacted]
SITE: BY WHOM: B6-2
COMMENTS: NO PODINE OR BETADINE.

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No				SPC	MAJ
Other	☐ Yes ☒ No					

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

IRAQI (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 35/35

☒ ESU NO: POE 000487
GROUND PAD: BRAND Valleylab
LOT NO: 20111

☐ 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.

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
N.S.

OTHER ORDERS None

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*
FLUFFS, KERLIX, ACE WRAP

19. ADDITIONAL INFORMATION
SURGEON = DR (b)(6)-2
WC = WY
ESU PAD SITE clean & Dry Pre & Post-OP

20. OPERATION(S) PERFORMED
I&D — STUMP REVISION of (L) ARM
(L) LEG DEBRIDE A

21. PATIENT TRANSFERRED TO ICU / TIME METHOD WHEEL

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia

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

3. DATE 9/11/03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM V TIME NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert + Oriented

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj CO4	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: 6

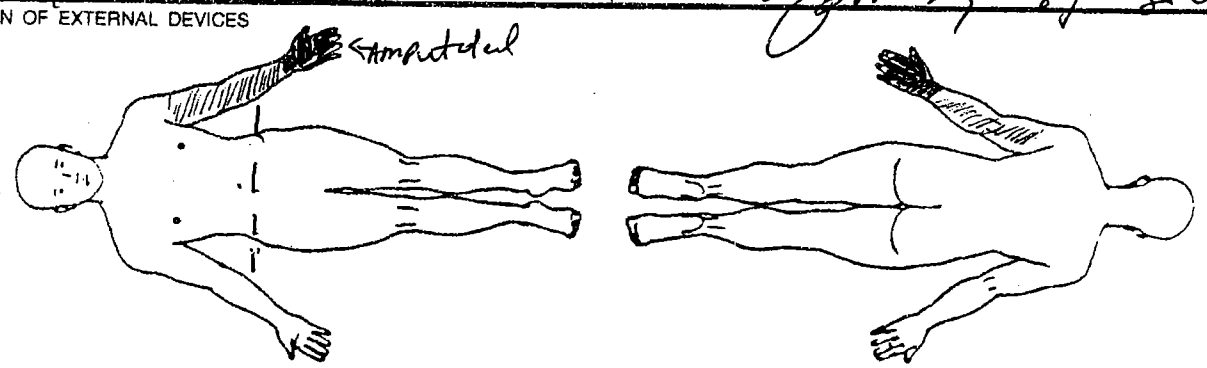
PREP SOLUTION *(Specify)* Betadine S&S

SITE (L) UE BY WHOM: Maj [redacted]

SITE: BY WHOM: B6-2

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	Spc (b)(6)-2	Maj (b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C	Spc	Maj
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

Frag: (b)(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

13. PROSTHESIS, IMPLANTS ☐ YES | IO | IF YES NAME: ID NUMBE | ANUFACTURER

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):

NSS X 2-L.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION (Specify)

(L) UE - Perlix, Fluff, Ace.

(L) LE - Kerlix's

19. ADDITIONAL INFORMATION

Dr.

Dr

(b)(6)-2

20. OPERATION(S) PERFORMED

I+D of (L) UE + (L) thigh

21. PATIENT TRANSFERRED TO I Cu | TIME 1045 | METHOD Bunney

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT

MEDCOM - 1304

*U.S. GPO: 1996-404-613/40449

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 13 Sept 03 TIME PATIENT ARRIVED IN SUITE 1805

4. PATIENT IN ROOM TIME 1805 NUMBER #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj		RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

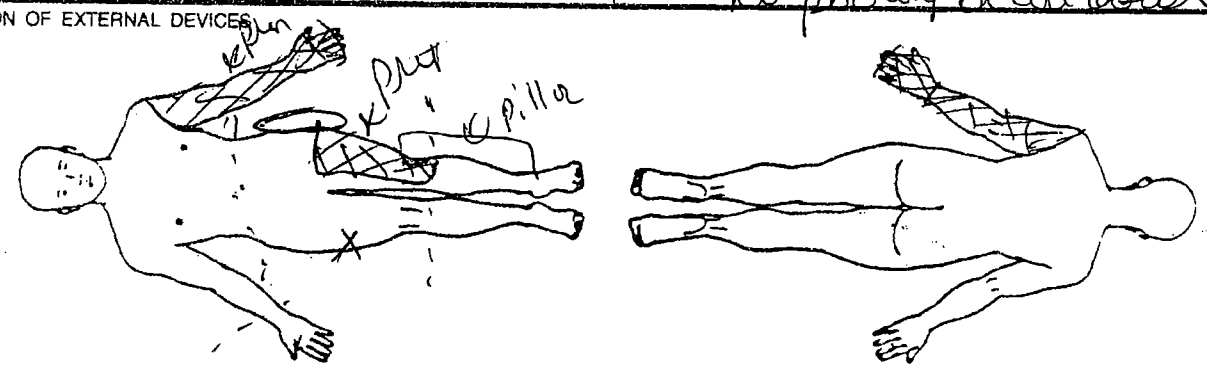
COMMENTS: Hip roll under (L) thigh & lower back - pillow between knees & under (L) knee

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (L) thigh & ext BY WHOM: [redacted] B6-2
SITE: (R) arm from stump to axilla circumferentially
COMMENTS: No pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No				(b)(6)-2	
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☒ Yes ☐ No					
Other	☐ Yes ☐ No					

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

IRAQI (b)(6)-4

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

☐ ESU NO: Valleylab 000434
GROUND PAD: BRAND E7507
LOT NO: 70011

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
kerlex
ace wrap
tape

19. ADDITIONAL INFORMATION

(b)(6)-2

20. OPERATION(S) PERFORMED

I&D @ thigh wound
I&D @ arm stump, A-line placement

21. PATIENT TRANSFERRED TO ICU-1 TIME See DA 2349 METHOD litter = safety straps

22. REGISTERED NURSE SIGNATURE (b)(6)-2 Maj/An

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1990-404-613/40449

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA i/TRL BY (b)(6)-2

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY (b)(6)-2 MAS SD

3. DATE 15 Sept 03 TIME PATIENT ARRIVED IN SUITE 1422

4. PATIENT IN ROOM TIME 1422 NUMBER R2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Explained via Translator

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

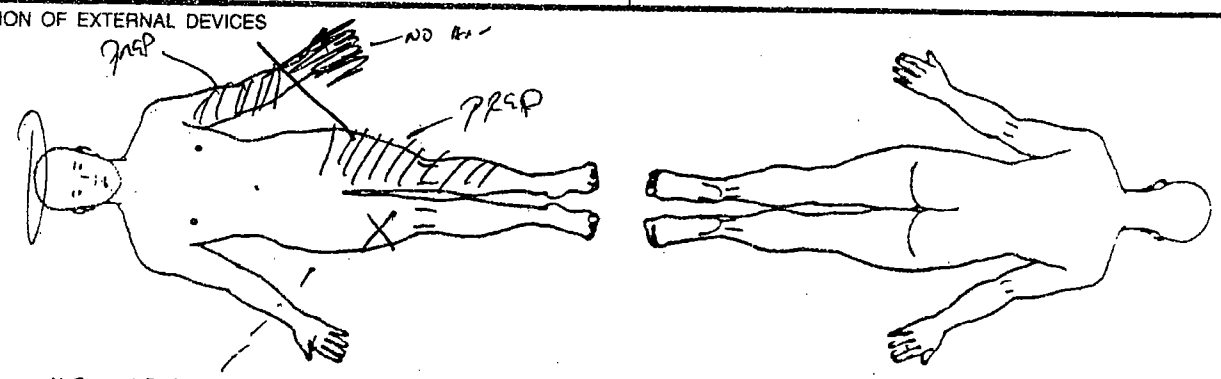
COMMENTS: all bony areas padded

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* BETA / BETA
SITE: (O) ARM & LEG BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: NO POOLING OR REACTION

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

IRAQ (b)(6)-4

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

35/38

☑ ESU NO: F0E000 434
GROUND PAD: BRAND Valleylab
LOT NO: 69621

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBE MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
None					

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):
N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16 Fr Foley	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluff, KARLYX, ACE, IODAFORM

19. ADDITIONAL INFORMATION
SURGEON = (b)(6)-2
WC = 4
ECU and site clean & dry Pre-OP, and Post-OP

20. OPERATION(S) PERFORMED
I&D of Stump (L) ARM, AND (L) LEG

21. PATIENT TRANSFERRED TO ICU | TIME 55 ANES START | METHOD LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MOT RN

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia

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

3. DATE 9/29/03 TIME PATIENT ARRIVED IN SUITE 1115

4. PATIENT IN ROOM TIME 1115 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: none

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: none

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

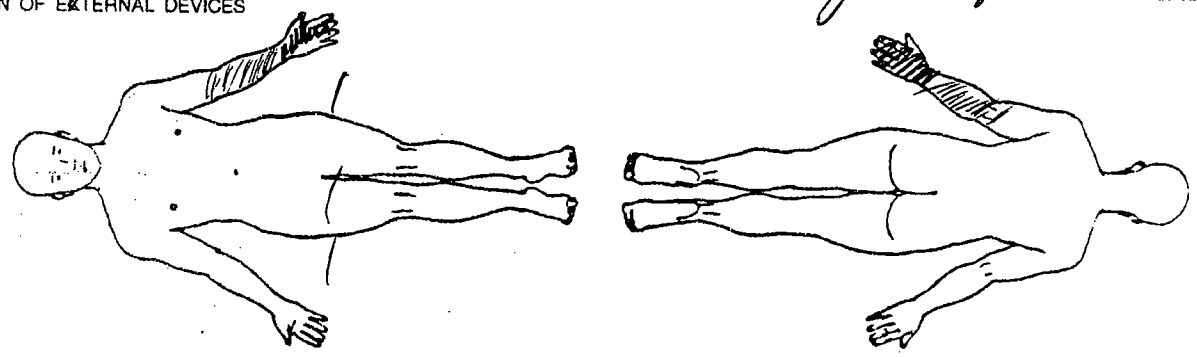
PREP SOLUTION *(Specify)* Betadine

SITE: LUE BY WHOM: CPT (b)(6)-2

SITE: BY WHOM:

COMMENTS: no pooling of soln

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS X 1 Wtr

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2 19 Sep 03

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, Ace

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/2" Foley	2.	3.
SITE	1. (L) UE stump	2.	3.

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

20. OPERATION(S) PERFORMED

I+D (L) UE

21. PATIENT TRANSFERRED TO ICU | TIME 1205 | METHOD Cart

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. GPO: 1996-404-613/40449

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	0

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 SPW2 LPN	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SPW2	ICU-2	26 Aug 03

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

Potus (b)(6)-4 (EPW)

- ☐ HISTORY PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2			2			2			2		2				–						2
	RADIAL L			UTA			UTA			UTA			UTA		★				–						UTA
	DORSALIS PEDIS R			2			2			2			2		2				–						UTA
	DORSALIS PEDIS L			2			2			2			2		2				–						UTA
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 7			1 3 7			1 3 7			1 3 7		1 3 7				– – –						1 3 7
EDEMA																									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓			✓			✓			✓		R				–						✓
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				NSR			NSR			NSR			NSR		NSR				–						NSR
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH			✓			✓			✓			✓												
	FOLEY CARE														✓				–						
	ORAL CARE																								
MOBILITY	BEDREST			✓			✓			✓			✓		✓				–						✓
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE			✓			✓			✓			✓		✓				–						✓
	HOB 30 DEGREES														✓				–						✓
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				★																					
PAIN	PAIN FREE			✓			✓			✓			✓		★		★		✓						★
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended			2			2			2			2		2				2						2
				✓																					
BOWEL SOUNDS (active all quads)															✓				✓						✓
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓			✓			✓			✓		✓				–						✓
VOIDING CLEAR, YELLOW URINE q.s.				✓			✓			✓			✓		✓				–						✓
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																								
(R) Abd Scar	Rashes, Lac's, etc			✓			✓			✓			✓		★				–						✓
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE	Fixator			✓			✓			✓			✓		★				–						✓
#2 (L) UE				✓			✓			✓			✓		★				–						✓
#3 (R) ANKLE				✓			✓			✓			✓		★				–						✓

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) JV	25 Aug 03	CDI, patent
Foley	Groin	25 Aug 03	patent

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank) --
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 28 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			3			4			4			4		4				–						3
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			4			4			4			4		X				–						4
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			5			5			5			5		X				–						5
GLASCOW COMA SCALE (A+B+C)			12			13			13			13		X				–						12
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R														3R				–						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L														3R				–						
MOVEMENT (See Motor Function Scale at Top of Page) — RUE			4			4			4					4				–						4
MOVEMENT — LUE			2			2			2					2				–						2
MOVEMENT — RLE			3			3			3					2				–						2
MOVEMENT — LLE			Ø			Ø			Ø					1				–						1
GRIP (S) Strong (W) Weak (-) absent — R			W			S			S					S				–						W
GRIP — L			PMP			PMP			PMP					X				–						PMP
RESPIRATIONS — REGULAR			✓			✓			✓					✓				–						✓
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED			✓			✓			✓					✓				–						✓
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL			5			5			5					5				–						5
BREATH SOUNDS — LUL			5			5			5					5				–						5
BREATH SOUNDS — RLL			5			5			5					5				–						5
BREATH SOUNDS — LLL			5			5			5					5				–						5
BREATH SOUNDS — BOTH BASES			✓			✓			✓					✓				–						✓
COUGH — NONE			✓			✓			✓					✓				–						✓
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt			RA			RA			RA															
VENTILATOR — FiO2																								RA
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)														RA				–						
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT # _____ — ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT LAST SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH						✓			✓					✓				✓						
INITIALS			✓																					✓

(b)(6)-2

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0145	95.4	115	19	131/82	95		103										RA
0200																	
0300	96.8	122	19	122/80	94		95										RA
0400	97.4	128	22	129/91	97		106										RA
0500	98.4	127	20	119/87	98		99										RA/NAD
0600	98.1	132	20	134/83	96%		105										RA/
0700	99.2	128	20	121/79	95%		98										RA
0800	98.0	128	18	133/88	96%		105										RA
0900	98.4	125	18	132/91	98%		102										RA
1000		131	23	137/85	95%	RA	107										
1100		126	20	147/81	95%		106										RA
1200		142	17	120/80	96%												MSO4 4mg IVP
1300																	
1400	101.9	75	28	132/75	96%		100										see MAR for ↑ temp.
1500																	
1600	101.7	147	21	113/64	96%		84										
1700	101.7																
1800	100.6	136	19	129/75	97%		96										
1900																	
2000	99.2	137	22	159/86	93%		111										
2100																	
2200	100.4	127	19	131/84	90		103										RA/NAD
2300																	
2400	100.6	131	19	137/84	94		106										RA

	INTAKE								OUTPUT						
	LR	NS	IVPB ANCEF	Ranitidine	BOLUS	Pen. G	GENT	Total	URINE	BM				Total	COMMENTS
0100	0/2								0/2						
0200	2000/3050								80/0/2						
0300	150/3150								100/50						
0400	150/3350								75/225						
0500	150/3450								55/280					OR EBL 200	
0600	150/3600	150/150	100/100				OR	Crystal + 3600	80/330					UOP 750	950
0700	150/3750	150/300							50/380						
0800	150/3900	150/450						8050	40/420						
8 HR	3900	450	100					8 HR 4450	420					8 HR 420 + 950	= 1370
0900	150/150	150		100					190						
1000	200/350				1000				160/350						Balloon 0930 ↑
1100	200/550								150/500						
1200	200/750								100/600						
1300	200/950								150/750						
1400	200/1150		50						100/850						
1500	200/1350			50	100				50/550						
1600	200/1550		50/50	50/50	100/100				150/800						
8 HR	1550		50	50	100			16 HR. 6200	1000					16 HR. 1420	
1700	200/200								50/50						
1800	300/400								75/125						
1900	200/600								25/150						
2000	200/800								100/250						
2100	200/1000					100/100			100/350						
2200	200/1200		50/50												
2300	200/1400														
2400	200/1600						100/100		205/555						
8 HR	1600		50			100	100	24 HR. 10050	555					24 HR 570	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Aug 03	0800		Pt resting NAD v/S stable MP CBS ASSESSMENT COMPLETE dressings intact LR C 150 cc/hr to CL to (R) JV, UO 100cc, will continue to monitor — (b)(6)-2
26 Aug 03	0410		Administered by RN on duty MSO4 3mg pain pain via IV — (b)(6)-2
26 Aug 03	0330		Collected blood via JV per physicians instruction d/t low UO order verbally changed from CBC, Chem 7 to just Chem 7, no CBC, pt recieving 500cc bolus of NS as well as IV medication also per physician instruction — (b)(6)-2
	0600		Pt resting s/s/s of distress AM assessment completed (1) foot frostbite dressing dry and intact (1) hand Amputation dressing dry and intact, Abdominal wounds mid line foley catheter patent 60cc/hr @ 0700 ~~Acti~~ JV line infusing NS @ 150cc/hr patent. (b)(6)-2
	0715		pt c/o pain 9-1400 MSO4 3mg given as per doctors Orders (b)(6)-2
	1000		D IVF to LR 200cc/hr as per doctors order started Pen G IV 2 million units q6 per doctors order, tetanus IG 250 units administered IM as per doctors orders, D, 5mg OT IM @ 0900 as per doctors Order SSB (b)(6)-2
26 Aug 03		1400	received report from day shift nurse, pt. Ø s/s of SOB, C/O pain to (L) leg (via interpreter) pain medication given see MAR. Dressing to (L) leg c̄ moderate yellow drainage, (L) UE Amp site CDI, scrapes to ABD OTA & pink, scrapes to (R) LE OTA & scabbed over, ~~C/O~~ error will cont. to monitor pt — (b)(6)-2 CPN
26 Aug 03		1530	Temp still elevated (see Vital sign sheet) wool blanket removed & cotton sheet replaced, cool towel applied to head, Dr. (b)(6)-2 in to see pt. Dressing d'd c̄ Dr. (b)(6)-2 to (L) LE, will cont. to monitor pt — (b)(6)-2 LR
26 Aug 03		1630	C/O pain (via interpretor) pain meds given see MAR — (b)(6)-2 LR

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 9/w/26	(b)(6)-2
(b)(6)-2 LPN	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On		(b)(6)-2	
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 9/w/26	ICU-2	27 Aug 03

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

Potus (b)(6)-4 (EPW)

- ☐ HISTORY/PHYSICAL
- ☑ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R			2			2									2							2		
	RADIAL L			DTA			DTA									A							DTA		
	DORSALIS PEDIS R			DTA			DTA									2							2		
	DORSALIS PEDIS L			DTA			DTA									2							2		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale				1 3 7			1 3 7									1 3 7							1 3 7		
EDEMA																A									
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)				✓			✓									R									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)				NST												NST									
SWAN GANZ CATHETER -(Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE															✓									
	ORAL CARE																								
MOBILITY	BEDREST			✓			✓									✓									
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE			✓			✓									✓									
	HOB 30 DEGREES			✓			✓									✓									
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)				A			A																		
PAIN	PAIN FREE															A									
	PAIN SCALE (1-10)			✓			✓																		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended				2			2									2									
BOWEL SOUNDS (active all quads)				✓			✓									✓									
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓			✓									✓									
VOIDING CLEAR, YELLOW URINE q.s.				✓			✓									✓									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds						✓									A									
(R) Dbed /se	Rashes, Lac's, etc			✓			✓																		
DRESSING (Dry & Intact: specify site below)																									
#1 (D) LE fixator				✓			✓									D									
#2 (D) LE amp				✓			✓									A									
#3 (R) ankle				✓			✓									A									
				(b)(6)-2																					

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	25 Aug 03	CDI, patent
Foley	Groin	25 July 03	patent

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE: 27 Aug 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open			3			3									4			4						
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			4			4									5			5						
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response			5			5									6			6						
GLASGOW COMA SCALE (A+B+C)			12			12									15			15						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R															2+			2+						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L															2+			2+						
MOVEMENT (See Motor Function Scale at Top of Page) — RUE			2			2									4			4						
MOVEMENT — LUE			AMP			AMP									A			A						
MOVEMENT — RLE			2			2									2			2						
MOVEMENT — LLE			1			1									2			2						
GRIP (S) Strong (W) Weak (-) absent — R			W			W									S			W						
GRIP — L			AMP			AMP									A			A						
RESPIRATIONS — REGULAR			✓			✓									✓			✓						
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED			✓			✓									✓			✓						
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL			5			5									5									
BREATH SOUNDS — LUL			5			5									5									
BREATH SOUNDS — RLL			5			5									5									
BREATH SOUNDS — LLL			5			5									5									
BREATH SOUNDS — BOTH BASES			✓			✓									✓									
COUGH — NONE			✓			✓									✓									
COUGH — SPONTANEOUS																		✓						
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																		R						
VENTILATOR — RATE (SIMV/CMV)																		C						
VENTILATOR — PEEP / CPAP																		O						
VENTILATOR — PRESS. SUPPORT																		O						
OXYGEN DELIVERY DEVICE — NC (l/min)			2			2									A			M						
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																		A						
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																		I						
ETT / NT SUCTIONED																		R						
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH						✓												✓						
INITIALS			(b)(6)-2																					

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	99.9	123	21	133/68	98		91										2LNC
0300	/	122	12	142/76	97		100										2LNC
0400	99.8	118	14	134/78	98		102										2LNC
0500																	
0600	98.4	112	14	142/85	98%		106										2LNC
0700		109	16	145/86	95%		107										2LNC
0800																	
0900	98.6	105	14	160/97	97%		122										2LNC
1000																	
1100																	
1200																	
1300																	
1400																	
1500	100.8	142	15	134/78	97%		97										1LNC
1600																	
1700	100.9	136	10	122/70	93%		89										RA
1800																	
1900	99.9	132	11	115/7	92%												RA
2000																	
2100	100.5	123	18	128/78	97%												
2200																	
2300	101.5	129	16	122/68	95%												RA
2400																	
~~0030~~																	

	INTAKE									OUTPUT						
	LR	NS	ANCEF	GENT	PEN G	D/H 20 mEq	OR		Total	URINE	BM	OR			Total	COMMENTS
0100	200 / 200									115 / 115						
0200	200 / 400															
0300	200 / 600				50 / 50											
0400	200 / 800															
0500	200 / 1000									250 / 250						
0600	100 / 1200									50 / 300						
0700	200 / 1400			50 / 50						60 / 360						
0800	200 / 1600									60 / 420						
8 HR									8 HR 1700 / 1650						8 HR 420	
0900					50 / 50	110 / 110				120 / 120						
1000																
1100																
1200																
1300																
1400	80 / 80						900 / 900				950 / 950					
1500	80 / 160				100 / 150					150 / 270						
1600	80 / 240			100 / 100						100 / 370						
8 HR	240			100	150	110	900		16 HR.	370	950				16 HR.	
1700	80 / 80									50 / 50						
1800	80 / 160		50 / 50							75 / 125						
1900	80 / 240									100 / 225						
2000	80 / 320									125 / 350						
2100	80 / 400		100 / 150							100 / 450						
2200	80 / 480									50 / 500						
2300	80 / 560									75 / 575						
2400	80 / 640		50 / 200							50 / 625						
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 Aug 03		2300	received report from previous shift @ 2220 drew lab from pt central line 2230 provided IVPB Antibiotic 2300 collected UA — [b)(6)-2] 9/WMG
26 Aug 03		2345	Assessment complete LRC 200cc/hr to (R) IJ, Foley to gravity 3 lead probes on chest PSO_2 probe on (R) toe (R) ankle gauze wrapping CDI, UTA pulse, cap refill <3sec, (R) thigh OTA abrasions, foley to gravity, attached to (R) thigh patent c yellow urine NAD (L) LE gauze c tape over pins c thigh bloody saturation to thigh no Δ per physicians instruction UTA (L) radial pulse d/t dressing to toes (L) LE drip c ace wrapping CDI, ID bracelet attached to (L) shoulder LS CTA abd flat abrasions along waist pt. not elev (R) IJ patent, bandaging blood tinged MPCBS, UTA pain level interpreter CBS — [b)(6)-2] 9/WMG
27 Aug 03	0015		Hep flushed (R) IJ by RN on duty 0115 pt put on 2L O_2 via NC PSO_2 89% by RT — [b)(6)-2] 9/WMG
27 Aug 03	0020		pt informed of NPO status — [b)(6)-2] 9/WMG
27 Aug 03	0235		pt c/o discomfort to (R) LE, RN on duty administered MSO4 — [b)(6)-2] 9/WMG
27 Aug 03	0300		Assessment complete PSO_2 probe (L) ear, pt on O_2 via 20% NCC 2L 97% no other changes from previous assessment. — [b)(6)-2] 9/WMG
	0600		AM Assessment completed VS P112 B/P 142/85 R 14 T98.4 IVF 2(R) 200cc/hr (D) Lung CTA, Congested (B) Lung. all Lobes SS — [b)(6)-2] 9/WMG
	0900		Dec 1R IVF Δ for D5½ 20Kcl as per doctor order SS — [b)(6)-2] 9/WMG
	1100		Pt in route to OR SS — [b)(6)-2] 9/WMG

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	Aug 25, 03
DOS	25 Aug
POD	~~25 Aug 03 (DDS)~~ 1

24 HOUR DATA	
24 Hour Balance	+1565
24 Hour Intake	3890
24 Hour Output	-2325
Weight on Admission	unknown
Weight Yesterday	unknown
Weight Today	unknown
hospital balance	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside			✓
Monitor Alarms On			✓
ID Bracelet On		J7	✓
Allergy Bracelet On			
Call Light Within Reach			N/A
Side Rails Up			N/A
Bed in Low Position			N/A

(b)(6)-2	Title)	Department/Service/Clinic	DATE
	Rg	ICU-2	Aug 28, 03

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

POTUS (b)(6)-4 (EPW)

- ☐ HISTORY/PHYSICAL
- ☒ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(*Specify*) Nursing notes
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

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1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2		2				2						2								2		
	RADIAL L		UTA		UTA				UTA						UTA								UTA		
	DORSALIS PEDIS R		UTA		1				1						1								UTA		
	DORSALIS PEDIS L		UTA		1				1						1								UTA		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 7		1 3 7				1 3 7						1 3 7								1 3 8		
EDEMA (R) arm					✓				✓														✱		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓		✓				✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			✓		✓				✓						✱								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓						✓										
	FOLEY CARE								✓						✓										
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR									✓															
POSITIONED	RIGHT																						A		
	LEFT																						S		
	SUPINE																						S		
	HOB 30 DEGREES		✓		✓				✓						✓								S		
FALLS PROTOCOL INITIATED																							+		
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																							✓		
PAIN	PAIN FREE		✓		✓																				
	PAIN SCALE (1-10)							5/10																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2		2				2						1								1		
BOWEL SOUNDS (active all quads)			✓		✓				✓						✓								✓x4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓		✓				✓						✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓		✓				✓						✓								✓		
SCARS	Rashes, Lac's, etc																						✓		
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE Fixator			✓		✓				✓						✓								✓		
#2 (L) UE Amp			✓		✓				✓						✓								✓		
#3 (R) Ankle			✓		✓				✓						✓								✓		
									✓																

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	25 Aug 03	Intact
Foley	Groins	Aug 25, 03	Patent

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 28 August 05

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open		4		4								4		4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response		5		5								5		5								5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response		6		6								6		6								6		
GLASGOW COMA SCALE (A+B+C)		15		15								15		15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R		+2		+2								+2		+2								+3		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L		+2		+2								+2		+2								+3		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE		4		4								4		4								4		
MOVEMENT — LUE		*		*								*		*								4A		
MOVEMENT — RLE		2		2								2		2								2		
MOVEMENT — LLE		2		2								2		2								2		
GRIP (S) Strong (W) Weak (-) absent — R		W		W								W		W								W		
GRIP — L		*		*								*		*								*		
RESPIRATIONS — REGULAR		✓		✓								✓		✓								✓		
RESPIRATIONS — IRREGULAR																								
RESPIRATIONS — UNLABORED		✓		✓								✓		✓								✓		
RESPIRATIONS — LABORED																								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL		5		5								5		5								5		
BREATH SOUNDS — LUL		5		5								5		5								5		
BREATH SOUNDS — RLL		1		1								1		1								1		
BREATH SOUNDS — LLL		1		1								1		1								1		
BREATH SOUNDS — BOTH BASES		1/1		1/1								1/1		1/1								✓		
COUGH — NONE		✓		✓								✓		✓										
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT # _____ — NRBM (l/min)																								
ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE													✓									✓		
COUGH / DEEP BREATH		✓		✓								✓		✓								✓		
INITIALS		(b)(6)-2																						

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	101.7	115	16	120/73	95%												RA
0300																	
0400	99.3	116	18	118/70	96%												RA
0500																	
0600	100.2	118	20	129/77	95%												RA
0700																	
0800																	
0900																	
1000	98.7																
1100																	
1200																	
1300																	
1400	101.9	130	22	119/59	95%												RA
1500																	
1600																	
1700																	
1800																	
1900	99.9																
2000																	
2100																	
2200	100.9	130	20	137/73	93%	—	93										
2300																	
2400																	

	INTAKE									OUTPUT						
	LR	IVPB Amcef	~~Gent~~	~~PEH~~	OR	PO			Total	Urine					Total	COMMENTS
0100	80 / 80									75						
0200	80 / 160									50 / 125						
0300	80 / 240	50 / 50		~~50~~						100 / 225						
0400	80 / 320									75 / 300						
0500	80 / 400									75 / 375						
0600	80 / 480	50 / 100								50 / 425						
0700	80 / 560									50 / 475						
0800	80 / 640	50 / 150				240 / 240				50 / 525						
8 HR	640	150				240			8 HR. 1030	525					8 HR 525	
0900	80 / 80									100 / 100						
1000	80 / 160					120 / 120				100 / 200						
1100	80 / 240									100 / 300						
1200	80 / 320	50 / 50				60 / 180				50 / 350						
1300	80 / 400					100 / 280				50 / 400						
1400	80 / 480					150 / 430				100 / 500						
1500	80 / 560	100 / 150				100 / 530				100 / 600						
1600	80 / 640	100 / 250				100 / 630				100 / 700						
8 HR	640	250				630			16 HR. ~~1520~~ 1550	700					16 HR. ~~700~~ 1225	
1700	80 / 80					250 / 250				100 / 100						
1800	80 / 160	50 / 50				150 / 400				100 / 200						
1900	80 / 240									100 / 300						
2000	80 / 320									100 / 400						625
2100	80 / 400	100 / 150								~~200~~ ~~525~~						
2200	80 / 480									100 / ~~625~~						
2300	80					100				300						
2400	80	50								75						
8 HR	640	200				500			24 HR. 3890	1100					24 HR ~~2325~~	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Aug 28, 03	0130		Resting well eyes closed. rises and fall of chest noted. Ø c/o discomfort at this time. Will cont to monitor per the order. (b)(6)-2
	0400		Sleeping NAD doing well. Ø Δ's from prior assessment. (b)(6)-2
	0600		received pt. NAD; resting c̄ eyes closed — (b)(6)-2
	0830		pt. received 2 mg MSO4 prior to sitting in chair; pt. had difficulty c̄ transfer to chair c̄ 75% assist; bath was given, will cont. to monitor (b)(6)-2
	1230		wound care on LLE done; pt. premedicated before dx Δ; will cont. to monitor — (b)(6)-2
		1445	Assessment completed. (R) IV infusing LR @ 80cc/hr. Ø S/S of infection. (L) upper extremity amputation, dressing CDI, clear serosanguous fluid noted on (L) leg at operative sites. Foley draining clear dark yellow urine, Abdomen distended, but normal active bowel sounds x4. Abrasions on abdomen C+D, Breath sounds CTA, c̄ demenished bases bilaterally. (b)(6)-2
		1800	Medicated c̄ MSO4 per orders for transfer to chair. (b)(6)-2
		1745	Pt medicated c̄ MSO4 per orders for pain. Pt sitting up in chair. Pt ate 30% of meal. Good PO fluid intake (b)(6)-2
		1830	Pt medicated c̄ ii Tylox per physician's order. Pt transferred Back to bed. moderate amount of drainage still noted from operative site on (L) lower extremity. ~~will cont~~ Good IS use. (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	
Hospital Balance	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2 BPC	
(b)(6)-2 CRN	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 CPT AN	ICU-2	29 Aug 03

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

POTUS (b)(6)-4 (EPW)

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(*Specify*) Nursing Note
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

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1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		2						2														2		
	RADIAL L		UTA						UTA						Amp								UTA		
	DORSALIS PEDIS R		UTA						UTA														UTA		
	DORSALIS PEDIS L		UTA						UTA														UTA		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8						1 3 8														1 3 8		
EDEMA (R) arm			*						*						*								—		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓						✓								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			ST						✓						ST								ST		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																						✓		
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																						✓		
	SUPINE																								
	HOB 30 DEGREES								✓						✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE			PF					✓														*		
	PAIN SCALE (1-10)														7/10								✓		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended														1								1		
BOWEL SOUNDS (active all quads)				↓B				↓							↓W4								X4		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT				✓				✓							✓								✓		
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds			✓				✓							✓								✓		
	Rashes, Lac's, etc			✓				✓							✓								✓		
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE ex fix				✓				✓							✓								✓		
#2 (L) UE				✓				✓							✓								✓		
#3 (R) ankle				✓				✓							✓								✓		

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
central line	(R) IJ	27 Aug 03	Opsite.

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 29 August 03

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open				4				4						4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response				5				5						5								5*		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response				6				6						6								6		
GLASGOW COMA SCALE (A+B+C)				15				15						15								15*		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R				3+				3+																
PUPIL RESPONSE — L				3+				3+																
MOVEMENT (See Motor Function Scale at Top of Page) — RUE				4				4						4								4		
LUE BEA				*				*						*								—		
RLE				4				4						4								4		
LLE				3				3						3								3		
GRIP (S) Strong (W) Weak (-) absent — R				W				W						W								W		
GRIP — L				—				—						—								AMP		
RESPIRATIONS — REGULAR				✓				✓						✓								✓		
IRREGULAR																								
UNLABORED				✓				✓						✓								✓		
LABORED																								
SHALLOW																								
RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL				5				5						5								5		
LUL				5				5						5								5		
RLL				1				1						1								1		
LLL				1				1						1								1		
BOTH BASES				1				1						1								✓		
COUGH — NONE				✓				✓						✓								✓		
SPONTANEOUS																								
PRODUCTIVE																								
NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
FiO2																						CA		
RATE (SIMV/CMV)																								
PEEP / CPAP																								
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
FM (l/min)														2L										
ETT # _____ — NRBM (l/min)																								
ETT _____ cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE														✓										
COUGH / DEEP BREATH				✓				✓						✓										
INITIALS				(b)(6)-2																				

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800	100.5	116	14	140/86	95%												RA
0900																	
1000																	
1100																	
1200																	
1300																	
1400	102.1	130	21	103/58	94%												2L O_2 NC
1500																	
1600																	
1700	99.7																
1800																	
1900																	
2000	99.4																
2100																	
2200																	
2220	99.6	107	19	127/75	98%		94										RA, NAD
2300																	
2400																	

	INTAKE									OUTPUT						
	LR	IVPD	OR	RR	PO				Total	Urine					Total	COMMENTS
0100	80 / 80									50						
0200	80 / 160															
0300	80 / 240	50 / 50														
0400	80 / 360									400 / 450						
0500	80 / 400															
0600	80 / 480	50 / 100														
0700	80 / 560															
0800	80 / 640									500 / 950						
8 HR	640	100							8 HR. 740	950					8 HR 950	
0900	80 / 720															
1000																
1100	80 / 800															
1200	80 / 880															
1300	80 / 960															
1400	80 / 1040				100 / 100					500 / 500						
1500	80 / 1120	100 / 100			100 / 200											
1600					100 / 300											
8 HR	480	100			200				16 HR.	500					16 HR.	
1700	80 / 560	100 / 100			240 / 240											
1800	80 / 640									500 / 500						
1900	80 / 720	100 / 200			100 / 340											
2000	80 / 800									125 / 625						
2100	80 / 880	100 / 300			100 / 440					150 / 775						
2200	80 / 960									150 / 925						
2300	80 / 1040															
2400	80 / 1120															
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27Aug03	04		Pt sleeping, easily arousable. 0 complaints @ this time. Encouraged a position change. done c̄ assist. Assessment complete pt back to clean.
	0530		Pt request med for (D) arm pain. MSO4 IV given. Reminded of NPO status. Given H_2O to rinse mouth and spit. Complete cooperation. Assistance given to move up in bed. — (b)(6)-2 (b)(6)-2
	0800		recieved pt this AM; NAD; VSS; pt. NPO for surgery; will cont. to monitor — (b)(6)-2
	1025		pt. returned from surgery; NAD; VSS; will cont to monitor — (b)(6)-2
	1230		Tmax 103.7; (b)(6)-2 informed; 650mg Tylenol given; will cont. to monitor — (b)(6)-2
		1410	Pt T- 102.1. JS and CDB done. Pt uncovered, and cooling measures initiated. Assessment completed. O A+O x 3. Breath sounds CTA c̄ diminished bases bilaterally. ~~Moderate~~ Minimal drainage from operative site noted at this time. ↓ Bowel sounds x 4. Good po fluid intake. Non tender to palpation. Will continue to monitor - J Flang
		1650	Occlusion noted from JS. Attempts to flush unsuccessful. (b)(6)-2 notified. O_2 Sat 95% on RA. — (b)(6)-2 RN
28Aug03	2210		pt received 650 mg Tylenol prn pain — (b)(6)-2
	2220		Assessment complete LRC 80cc/hr to (R) IJ, patent & intact, b/p cuff to (R) arm PSO_2 monitor to (L) earlobe, (L) Amp UE elevated pt responds to commands, opens eyes spontaneously, interpreter CBS, MP CBS ID bracelette to (R) wrist (R) ankle gauze wrap c̄ small amount of yellow fluid drainage to toes, (L) LE elevated, calf

(b)(3)-1

DARNALL ARMY COMMUNITY HOSPITAL

LOS DATA	
DOA	25 Aug 03
DOS	25 Aug 03
POD	4

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 91WM6	(b)(6)-2
(b)(6)-2 SPC 91WMC	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On		(b)(6)-	
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 91WM6	ICU-2	30 Aug 03

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

Potus (b)(6)-4 (EPW)

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2				2															2	
	RADIAL L				VTA				VTA															VTA	
	DORSALIS PEDIS R				VTA				VTA															VTA	
	DORSALIS PEDIS L				VTA				VTA															VTA	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					2 3 8				1 3 8															1 3 8	
EDEMA					—				✓															✗	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓				✓															✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					NSR				✓															NSR	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST				✓				✓															✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓																			✓	
	HOB 30 DEGREES								✓															✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)					—																			✗	
PAIN	PAIN FREE				✓				✓															✓	
	PAIN SCALE (1-10)																								
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				1				1															1	
BOWEL SOUNDS (active all quads)					x4				x4															x4	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT					✓				✓															✓	
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown				✓																			✓	
	Surgical Wounds								✓															✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) LE Ex fix					✓				✓															✓	
#2 (L) LE					✓				✓															✓	
#3 (R) ankle					✓				✓															✓	
					(b)(6)-2																				

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
CL	(R) IJ	27Aug03	Intact
Foley	GROIN	25Aug03	patent

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE: 30 Aug 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					4				4						4									4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					5				5						5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					6				6						6									6	
GLASGOW COMA SCALE (A+B+C)					15				15						15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				4				4						4									4	
	LUE				AMP				AMP						AMP									AMP	
	RLE				3				3						3									3	
	LLE				2				2						2									2	
GRIP (S) Strong (W) Weak (-) absent	R				W				W						W									W	
	L				—				AMP						AMP									AMP	
RESPIRATIONS	REGULAR				✓				✓						✓										
	IRREGULAR																								
	UNLABORED				✓				✓						✓									✓	
	LABORED																								
	SHALLOW																							✓	
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				—				5						5									3	
	LUL				—				5						5									3	
	RLL				—				1						1									1	
	LLL				—				1						1									1	
	BOTH BASES				✓				✓						1/1									✓	
COUGH	NONE				✓				✓															✓	
	SPONTANEOUS														✓										
	PRODUCTIVE																								
	NONPRODUCTIVE														✓										
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt				RA				RA						RA									RA	
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																								
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE															✓										
COUGH / DEEP BREATH									✓						✓										
INITIALS					(b)(6)-2																				

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600	100.4	70	20	121/74	91%												
0700																	
0800																	
0900																	
1000	102.5 (A)	161	18	120/78	91%												
1100																	
1200																	
1300																	
1400	101.9	118	24	116/56	93%												RA
1500																	
1600	100.9																
1700	100.4																
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2320	100.9	117	20	128/72	90%		91										RA/NAD
2400																	

	INTAKE									OUTPUT						
	LR	PO	IVPB						Total	URINE	BM				Total	COMMENTS
0100	80 / 80															
0200	80 / 160															
0300	80 / 240															
0400	80 / 320	100 / 100														
0500	80 / 400		50 / 50							975 / 975						
0600	80 / 480		100 / 150													
0700	80 / 560															
0800	80 / 640									400 / 1375						
8 HR	640		150						8 HR 790	1375					8 HR 1375	
0900	80 / 80															
1000	80 / 160	120 / 120														
1100	80 / 240															
1200	80 / 320	120 / 240														
1300	80 / 400	240 / 480														
1400	80 / 480	100 / 580	100 / 100							600 / 600						
1500	80 / 560	100 / 680	100 / 200							100 / 750						
1600	80 / 640	100 / 780	100 / 300							125 / 875						
8 HR	640	780	300						16 HR.	875					16 HR.	
1700	80 / 80	240 / 240								100 / 100						
1800	80 / 160		100 / 100							125 / 225						
1900	80 / 240		100 / 200													
2000	80 / 320															
2100	80 / 400															
2200	80 / 480									700 / 925						
2300	80 / 560															
2400	80 / 640		50 / 250													
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
8/30/03	A.M.	P.M.	
0600			recieved pt this AM; NAD; VSS; will cont to monitor (b)(6)-2
		1400	Pt received in bed. Moderate drainage noted from (L) leg. (D) Amputation of R extremity CDI. Lung sounds CTA c̄ diminished bases. Abdomen grossly distended, minimal bowel sounds. IS q 1°. IJ TLC CDI ∅ s/s of infection noted. NST. Will continue monitor. (b)(6)-2
		1645	Pt remediated c̄ 4mg MSO4 to aid OOB. Drainage from operative site, still moderate Will continue to monitor (b)(6)-2
		1730	Pt medicated c̄ ii Tylox for pain, Dr (b)(6)-2 notified of Abdominal distention Pt Per Dr (b)(6)-2 ∅ solid foods. Will continue to monitor. (b)(6)-2 LBN
Aug 30, 03		2330	pt put on supplimental O2 via NC @ 4L q/t PSO2 @ 90% current PSO2 93% (b)(6)-2
		2335	Assessment complete (L) LE are wrapped ap CDI, (R) IS CL CDI, patent (R) UE non-pitting edema ∅ c/o numbness cap refill <3sec. MPC BS (L) LE stitches OTA CDI, lacerations from thigh to ankle (R) foot edematous cap refill <3sec sluggish. Lacerations to (R) LE, pt moves extremities x4, abd rounded, distended, LS Rhonchi upper lobes, diminished lower lobes pt resting supine c̄ HOB elevated 30 degrees PSO2 probe on ~~Rig~~ Every (R) hand c̄ constant supervision, 80cc/hr LR infusing into CL (R) IJ (b)(6)-2
		2345	Administered Tylenol for elevated temp 100° will reassess temperature (b)(6)-2
	0025		Begins blood administration (b)(6)-2
Aug 31, 03	0310		Assessment complete B/P cuff on (R) arm

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	31 Aug 03.
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2

Safety Checks	D	E	N
BVM at bedside		(b)(6)-2	(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LAN.	ICU #1	31 Aug 03

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

Lofus *(b)(6)-4

☐ HISTORY-PHYSICAL ☐ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R																2						2		
	RADIAL L																2						2		
	DORSALIS PEDIS R																1						1		
	DORSALIS PEDIS L																1						1		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale																	1/3/8						1/3/8		
EDEMA																	+1						1		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)																									
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)																									
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																P								
	ORAL CARE																e								
MOBILITY	BEDREST																r								
	BSC																A								
	DANGLE																M								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																								
	HOB 30 DEGREES																								
FALLS PROTOCOL INITIATED																	✓						✓		
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																0/10						3-7/10		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended																1	1					1		
BOWEL SOUNDS (active all quads)																	*						*		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																	✓								
VOIDING CLEAR, YELLOW URINE q.s.																	✓								
SKIN INTEGRITY	No Breakdown																								
	~~Surgical Wounds~~																*						*		
	Rashes, Lac's, etc																*								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

(b)(6)

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(R) IJ	(R) IJ	27 Aug 03	c/d/i -

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE: 31 Aug 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open				4			4																		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response				5			5																		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response				6			6																		
GLASCOW COMA SCALE (A+B+C)				15			15																		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R						–																		
	L						–																		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE			3			4																		
	LUE			UTA			–																		
	RLE			3			3																		
	LLE			3			3																		
GRIP (S) Strong (W) Weak (-) absent	R			S			S																		
	L			UTA			–																		
RESPIRATIONS	REGULAR						✓																		
	IRREGULAR																								
	UNLABORED			✓			✓																		
	LABORED																								
	SHALLOW			✓																					
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL			3			5																		
	LUL			3			5																		
	RLL			1			1																		
	LLL			1			1																		
	BOTH BASES			✓			1																		
COUGH	NONE			✓			✓																		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)			4L			1																		
	FM (l/min)																								
ETT #_____	NRBM (l/min)						--																		
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2																						

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0110	100.2	~~80~~ 114	20	129/66	94%		90										4L NC/NAD
0200																	
0240	99.2	111	20	124/71	94%		92										4L NC
0300																	
0340	99.2	109	20	129/78	98%		92										RA
0400																	
0440	99.6	107	18	126/75	97%		91										RA/MSOY
0500																	
0505	98.5	109	18	129/82	97%		100										
0600		109	20	132/81													RA/NAD
0700	100	105	18	121/78			97%	RA									
0800	99.5	105	18	129/78													2nd U PRBC complete
0900																	
1000																	
1100																	
1200	101.9																Tylenol
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

	INTAKE									OUTPUT						
	RBC	LR	PO	IVPB					Total	URINE		BM			Total	COMMENTS
0100										325 / 325						
0200																
0300										200 / 525						
0400	400 / 400		100 / 100							100 / 625						
0500		80 / 80								100 / 725						
0600		80 / 160	50 / 150							550 / 2325						
0700		80 / 240								200 / 2525						
0800	400 / 800	80 / 320								50 / 2575						
8 HR	800	320		150					8 HR. 1270	2575					8 HR 2575	
0900	80			50												
1000	80 / 160															
1100	80 / 240															
1200	80 / 320															
1300	80 / 400									950 / 950						
1400	80 / 480															
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 Aug 03	0310		(continued) PSO_2 monitor on (R) hand. RBC transfusion continuing with (R) IJ CL, pt continues to place pressure on line, MPC BS. Abd cramping pt discomfort but pt denies pain to that area, UO remains adequate — (b)(6)-2 SI/Neuro
	0330		pt's efforts to stop flow of blood had dislodged IV, IV was removed, client currently sats @ 97% @ RA will continue to monitor — (b)(6)-2 SI/Neuro
31 Aug 03	0425		First unit of RBCs administered — (b)(6)-2 SI/Neuro
	1455		Initiated 2nd Unit PRBC Unit # 55 T20132. See separate progress note for vitals. Pt remains alert and request H_2O. Ice given to rinse and spit. NPO status effective. Blood infusing w/ difficulty. ∅ reaction observed in 1st 15 minutes. Will continue to monitor c LOS care. — (b)(6)-2 CP/AN
31 aug 03	0600 hrs		Report received, assumed care of pt. #2 u PRBCs infusing into (R) IJ TLC. See flowsheet for details of assessment. Pt using incentive spirometer. Abd cont distended, mildly firm + tympanic to palpation. BS x4, ~~higher~~ tinkling and high pitched in all 4 quads. (L) LE incision open to air, sutures intact ∅ drainage noted. — (b)(6)-2 HAT RN
	0800 hrs		2nd u PRBCs completed. Pt medicated c Percocet PO ~~etc~~ to get OOB. — (b)(6)-2 HAT RN
	1000 hrs		Pt back to bed, up in chair x1 hr. Dulcolax suppository given per Dr (b)(6)-2 Pt placed on bedpan. Repeat labs done. — (b)(6)-2 HAT RN
	1245 hrs.		Pt requested bedpan. Sm amt smearing of stool ∅ BM. (R) IJ TLC continues very positional, c/o infusing fmd fast (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 SPecialist	(b)(6)-2
(b)(6)-2 MAJ AN	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 Specialist	ICU-2	31 Aug 03

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

Potus (b)(6)-4 EPW

☐ HISTORY PHYSICAL ☐ FLOWCHART

☐ OTHER EXAMINATION Or EVALUATION ☒ OTHER(Specify) PROGRESS NOTES

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 91WM2	(b)(6)-2
(b)(6)-2 MAJ AN	

Safety Checks	D	E	N
BVM at bedside			
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 91WM2	ICU-2	31 Aug 03

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

Potus (b)(6)-4 EPW

- ☐ HISTORY PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☒ OTHER(Specify) PROGRESS NOTES
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700
1 MAY 78

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500																	
0600																	
0700																	
0800																	
0900																	
1000																	
1100																	
1200																	
1300																	
1400																	
1500																	
1600	101.5	90	18	125/74													
1700																	
1800	100.8																
1900																	
2000																	
2100																	
2200																	
2300																	
2400																	

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes N
No Change from Previous Assessment --

DATE:

TIME	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open																4						4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response																5						5		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response																6						6		
GLASCOW COMA SCALE (A+B+C)																15						15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R																[illegible]								
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L																+								
MOVEMENT (See Motor Function Scale at Top of Page) — RUE																5						5		
MOVEMENT — LUE																0						2		
MOVEMENT — RLE																3						3		
MOVEMENT — LLE																3						3		
GRIP (S) Strong (W) Weak (-) absent — R																5-						5		
GRIP — L																-								
RESPIRATIONS — REGULAR																						5		
RESPIRATIONS — IRREGULAR																5								
RESPIRATIONS — UNLABORED																						5		
RESPIRATIONS — LABORED																5								
RESPIRATIONS — SHALLOW																								
RESPIRATIONS — RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished — RUL																						5		
BREATH SOUNDS — LUL																5						5		
BREATH SOUNDS — RLL																5						4		
BREATH SOUNDS — LLL																4						4		
BREATH SOUNDS — BOTH BASES																5						+		
COUGH — NONE																						✓		
COUGH — SPONTANEOUS																								
COUGH — PRODUCTIVE																								
COUGH — NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																								
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																								
VENTILATOR — Vt																								
VENTILATOR — FiO2																								
VENTILATOR — RATE (SIMV/CMV)																								
VENTILATOR — PEEP / CPAP																								
VENTILATOR — PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE — NC (l/min)																								
OXYGEN DELIVERY DEVICE — FM (l/min)																								
ETT #_____ — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS																(b)(6)-2								

	INTAKE									OUTPUT						
	iV	iVPB							Total						Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700		250 / 250														
1800		225 / 500								350					Foley o/c'd	
1900																
2000																
2100																
2200																
2300																
2400																
8 HR									24 HR.						24 HR	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
31 Aug 03		1530	Pt. arrived/assisted transport from icu #2. VSS-fchk @ 1015 - previously given tylenol. Will re-assess later, promote is use. Dressing dated - c̄ ⊕ weeping ⊕ thigh. (b)(6)-2
		1730	Pt. ↑ - used BSC - ⊕ bowel stool - approx 100cc. Pat care per order - temp re-check @ 1800. Interpreter called several times to explain NPO status. Pain med - Tylox x2 for ⊕ leg pain ⊕ LE. Positioned for comfort. Pat. monitn. (b)(6)-2
31AUG03		2100	IJ d/c'd following KCL infusion. Stitches removed / pressure applied for 5min. OPSITE IN PLACE OVER 2x2 - ⊖ drng noted c this time (b)(6)-2
		2150	Assumed care of pt, Drsg Δ performed pt tolerated well. Redressed per order.
		2230	Pt c̄ c/o pain to LE. Δ Chlorazone order given. pt medicated per order. will monitor for effect. (b)(6)-2
		2300	Assessment per flowsheet. ⊕ needs c̄ ogrito and 2oz drg D&I, abd distended hyperactive bowel sounds x4 quads, short LUQ, more active RLQ. Tympany to percussion LLE ace wrap D&I ⊖ drainage noted LLE Drsg D&I small amt of drainage noted posterior lateral portion. (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	~~1 Sep~~ 25Aug03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2 CPT/AN	
(b)(6)-2 LPN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On	NA		
Call Light Within Reach	NA	(b)(6)-2	
Side Rails Up	NA		
Bed in Low Position	NA		

PREPARE (b)(6)-2 and Title) RN

Department/Service/Clinic Icu 1

DATE 1 Sep 03

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

Potus (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

9VI

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1 MAY 78

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2							0										
	RADIAL L							NA							NA										
	DORSALIS PEDIS R							2							2										
	DORSALIS PEDIS L							2							2										
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale								1 3 8							1 3 8										
EDEMA								+1							+1										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓							✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								✓							✓										
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE							✓																	
MOBILITY	BEDREST							✓							✓										
	BSC																								
	DANGLE																								
	CHAIR							✓																	
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE							✓							✓										
	HOB 30 DEGREES							✓							✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE														✓										
	PAIN SCALE (1-10)							NA																	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							2							1										
BOWEL SOUNDS (active all quads)								NA							ND										
NG / DOBHOFF PLACEMENT VERIFIED															✓										
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds							✓							✓										
	Rashes, Lac's, etc														✓										
DRESSING (Dry & Intact: specify site below)																									
#1 (R) thigh								Ø							Ø										
#2 (R) UE																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
IVP	(R) Arm	~~15 Sept~~ 31 Aug 03	Ø SS inf, CDI, patent
PIV	(R) arm	31 Aug	Ø S/S of infection / infiltration

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	Not Applicable /Absent (blank)
			3 = Active: against gravity, but not against resistance	
4 mm	L > R	Left Larger	4 = Active: Against Gravity and Resistance, not full strength	Refer to Nsg. Notes X
			5 = Full Strength against Examiners Resistance	
5 mm	R > L	Right Larger		No Change from Previous Assessment --

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open								4							4										
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response								5							5 mono										
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response								6							6										
GLASCOW COMA SCALE (A+B+C)								15							15										
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																								
	L																								
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							5							5										
	LUE							NA							NA										
	RLE							5							5										
	LLE							2							2										
GRIP (S) Strong (W) Weak (-) absent	R							5							5										
	L							NA							NA										
RESPIRATIONS	REGULAR							✓							✓										
	IRREGULAR																								
	UNLABORED							✓							✓										
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5							5										
	LUL							5							5										
	RLL							5							5										
	LLL							5							5										
	BOTH BASES							5							5										
COUGH	NONE							✓							✓										
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)														3										
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS								(b)(6)-2																	

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200	102.8	129	27	113/64	93%												
0300																	
0330	101																
0400																	
0500																	
0600																	
0700																	
0800																	
0900	98.7°																
0930		116	30	132/83	93%												
1000	101.6° (A)	~~108~~															
1100																	
1200																	
1300																	
1400																	
1500																	
1600	100° ax	130	32	123/74	94%	on 1 l NC											tylenol given
1700																	
1800	101° ax																
1900																	
2000	101.2 100°	124	20	112/75	95%	2 L NC											
2100																	
2200																	
2300																	
2400																	

	INTAKE									OUTPUT						
	IV (05 NS 500 KCl)	IV ~~NS~~ new Infusion	LR						Total	Urine	NG				Total	COMMENTS
0100	100															
0200	100 / 200															
0300	100 / 300															
0400	100 / 400															
0500	100 / 500									360						
0600	100 / 600	50 / 50														
0700	100 / 700															
0800	100 / 800															
8 HR	800	50							8 HR ~~800~~ 0850						8 HR	
0900	100															
1000	100 / 200	50 / 50														
1100	100 / 300	100 / 150														
1200	100 / 400	50 / 200														
1300	~~0~~ to OR															
1400		~~200~~	~~700~~							300						
1500	100 / 500															
1600	100 / 600									375 / 675						
8 HR	600		700						16 HR. 1300	675					16 HR. ~~675~~ → 1035	
1700	~~100~~ / 100															
1800	100 / 200	50 / 50														
1900		100 / 150														
2000	100 / 300															
2100	100 / 400															
2200	100 / 500															
2300		150 / 300														
2400	100 / 600									~~300~~ 350	250					
8 HR	600	300	~~700~~						24 HR. 2100	350	250				24 HR 1635	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes) OBSERVATIONS Include medication and treatment when indicated
DATE	HOUR A.M.	HOUR P.M.	
15 Sep 03	0100		Pt sleeping soundly. Resp even and unlabored, will continue to monitor (b)(6)-2
	0215		VSS as charted. Tylenol 650 given per order pt ∃ distress. ⊖ change in assessment
	0400		Pt sleeping well, ∃ complaints, RR-20 will continue to monitor (b)(6)-2
	0530		Pt voided QS, dark clear amber urine. ⊖ complaints or difficulty. (b)(6)-2
	0745		Dsg Δed to (R thigh) pain meds adm., pt has BEA(R) ace wrap to it. Ex fix (R thigh) Will cont to monitor (b)(6)-2
	1100		@ 1030 NGT placed: Placement good, to LIS. pt O_2 sat @ 88% order obtained for prn O_2 3L NC. temp @ 101.6 (R) F. Tylenol PR adm will cont to monitor. (b)(6)-2
	1315		@ 1305 pt to OR (b)(6)-2
15 Sep 03	1400		PT back from OR - refer to PACU sheets for details. (b)(6)-2
15 Sep 03		1830	Rec'd report and assumed care of Pt. VSS - febrile @ 101°. Pt. rec'd anti-emetic @ 1640 - monitor temp. No % pain. NGT - LIS - Approx 60cc greenish drainage. PIV infusing ∃ s/s complication. Dressings intact - Pt. resting ∃ s/s of acute distress. Cont. monitor. (b)(6)-2
"		1940	T @ 101.2. Antipyretic due 2000 - N/V check temp and administer (b)(6)-2
16 Sep 03			Pt Temp ✓ - 100° - antipyretic on hand - No % pain - initially % hunger / thirst; however, declined food + s.p.t water due to NPO status. N/V cont. monitor and encourage to use. (b)(6)-2
		2115	Tympan exp & dressings changed - N-Sy Nelix drain ✓. Pt tolerated well. (+) Fungal - Necrotic tissue - (+) yellow kidney edges. N/V Cont monitor. (b)(6)-2
		2200	Assumed care of pt. ⊖ distress noted. SGT (b)(6)-2 (b)(6)-2 will continue primary care.

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	1 Sep 03
POD	1

24 HOUR DATA	
24 Hour Balance	+ 465
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 LPN.	(b)(6)-2
(b)(6)-2 LT, AN	
(b)(6)-2 CCRN	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	/	/	/
Side Rails Up	/ A	/ A	/
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN.	ICU #1	2 Sep 03

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

Lotus # (b)(6)-4

☐ HISTORY PHYSICAL ☒ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1359

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R				2				2				2		2									2	
	Brachial L				2				2				2		2									2	
	DORSALIS PEDIS R				1				2				2		2									2	
	L				1				2				2		2									2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale					1/3/8				1/3/8				1/3/8		1/3/8									1/3/8	
EDEMA								LES 1+				LES 1+			1+									1+	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)					✓				✓				✓		✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)					ST				ST				ST		ST									ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH								✓																
	FOLEY CARE										✓														
	ORAL CARE				✓										✓										
MOBILITY	BEDREST								✓				✓		✓									✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE				✓				✓				✓		✓									✓	
	HOB 30 DEGREES				✓				✓				✓		✓									✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE				✓				✓				✓		✓										
	PAIN SCALE (1-10)																							✓	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended				1				1				1		1									1	
BOWEL SOUNDS (active all quads)					*				Hyp x4				Hyp x4		LBS									✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.					*				✓				✓		✓									✓	
SKIN INTEGRITY	No Breakdown								✓				✓		✓									✓	
	Surgical Wounds				✓				✓				✓		✓									✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 (L) Thigh									✓				✓		✓									✓	
#2 (R) Arm Amputation									✓				✓		✓									✓	
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(R) 4 Arm.	(R) 4 Arm.	31 Aug 03	4/0 - Patent. 1070DX 1100
(R) arm 18ga	"	31 AUG 03	Ds/2 of inf/Infiltrated 1-07

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open					4			4					4		4									4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response					5			5					5		5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response					6			6					6		6									6	
GLASCOW COMA SCALE (A+B+C)					15			15					15		15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R				+										+										
	L				+										+										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE				4			4					4		4									4	
	LUE				/			3					3		3									3	
	RLE				2			4					4		4									4	
	LLE				3			2					2		2									2	
GRIP (S) Strong (W) Weak (-) absent	R				5			5					5		5									5	
	L				/										—									—	
RESPIRATIONS	REGULAR				✓			✓					✓		✓									✓	
	IRREGULAR																								
	UNLABORED				✓			✓					✓		✓									✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL				5			5					5		5									5	
	LUL				5			5					5		5									5	
	RLL				5			5/1					5/1		5									5	
	LLL				5			5/1					5/1		5									5	
	BOTH BASES							5/1					5/1		5									5	
COUGH	NONE				✓			✓					✓		✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)							2L					2L		2L									0	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS																									

(b)(6)-2

(b)(6)-2

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100	101.4																
0200																	
0300																	
0400	100.5	110	18	117/71	98% 3L												
0500																	
0600																	
0700	99.7(A)	107	26	109/67	95%												
0800																	
0900																	
1000																	
1100	102.2(A)	116	36	95/68	90%												
1105		114	28	114/69	95%												
1200																	
1300																	
1400																	
1500																	
1600																	
1700																	
1800																	
1830	100.4	102	26	123/72	95%												
1900																	
2000																	
2100																	
2140	100.4	109	30	114/68	96%												
2200																	
2300																	
2400																	

	INTAKE									OUTPUT						
	P.V	IVPB	PO	PRBCs					Total	URINE	NGT				Total	COMMENTS
0100	100/100									550/550						
0200	100/200															
0300	100/300															
0400	100/400									400/950	100/100					
0500	100/500															
0600	100/600	50/50								300/1250	~~100~~/~~40~~					
0700	100/700															
0800	100/800	50/100														
8 HR	800	100							8 HR. 900	1250	100				8 HR 1350	~~75~~-450
0900	100/100															
1000	100/200	50/50								450/450						
1100	100/300															
1200	100/400	100/150														
1300	50/450			50/50						125/575						
1400	0/450			100/150							200/200					
1500	100/550			100/250						600/1175						
1600	100/650			50/300						500/1675						
8 HR	450	150		300					16 HR. 800	1675	200				16 HR. 1875	
1700	50/50									550/550						
1800	100/150									400/950						
1900	50/200	50/50														
2000	50/250	50/100								400/1350						
2100	100/350															
2200	100/450															
2300	100/550									250/1600						
2400	100/650	50/150														
8 HR	650	150							24 HR. 2600	1600					24 HR. 3475	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 Sep 03	0100		Pt sleeping s/ Sx of acute distress. Has voided 550cc c/p urine. No c/o pain. No Δ in assessment. Dressing - w/o - (+) breakthrough drainage. Reinforced - Cont. Mon. for. — (b)(6)-2 LPN
	0140		TC 101.4 :: 650mg Tylenol PR per order. Mon. for effect. — (b)(6)-2 LPN
			Addition: Pt turned forward (R) side to relieve pressure from backside - 1:1 attempt to reposition frequently. — (b)(6)-2 LPN
	0400		Pt awake & void via urinal. No c/o pain - Temp ↓ c/o 100.3 - placed supine. NG - 100 ml drainage 04-04. Cont. monitor. Dressing reinforced c̄ comfort. — (b)(6)-2 LPN
9/2/03	0700		Linen Δ'd & bed bath given. NAD noted. Continues to have clear to serous drainage from LLE. (-) c/o discomfort. EX-Fix to LLE intact. ACE Drsg to LUE CDS & I. VSS will continue to monitor. — (b)(6)-2 LCT, RN
9/2/03	1100		Drsg Δ to LE. Small amt of sanguinous drainage. (-) odor. Tissue dull pink color. (-) purulent discharge. NS wet to dry Drsg reapplied. Pt tolerated procedure well. — (b)(6)-2 LCT, RN
9/2/03		1230	Began 1st unit of PRBC's. See SF 509 for V.S. maintenance
~~15SEP03~~			IV stopped by Dr (b)(6)-2 until p̄ blood (b)(6)-2 LCT, RN.
25SEP03		1830	2d unit of PRBC complete. IV site changed to (-) hand 18GA. due to pt c/o pain @ prior site. Pt resting comfortably @ this time. — (b)(6)-2
		2200	Assumed care of pt, assessment per flowsheet.
		2230	pt c̄ c/o continued pain. Medicated (-) 2100 for c/o pain. Discussed c̄ Dr (b)(6)-2 Order given. (b)(6)-2
		2300	Pt medicated, repositioned, will monitor for effect. (b)(6)-2

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	25 Aug 03
DOS	1 SEP 03
POD	2

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	(b)(6)-2
(b)(6)-2	
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED B (b)(6)-2 itle)	Department/Service/Clinic	DATE
RN	ICU 1	3 Sep 03

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

Potus (b)(6)-4

☐ HISTORY/PHYSICAL ☒ FLOWCHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700
1 MAY 78

MEDCOM - 1365

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R							2			2				2									2	
	BRACHIAL L							2			2				2									2	
	DORSALIS R							2			2				2									2	
	PEDIS L							2			2				2									2	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale (10) HOT								1 8 10			1 8 10				1 8 10									1 3 8	
EDEMA							LES	1+			1+				+1									+	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)								✓			✓				✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)								ST			ST				ST									ST	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)										✓															
HYGIENE	BED BATH	✓																							
	FOLEY CARE																								
	ORAL CARE	✓						✓			✓														
MOBILITY	BEDREST																								
	BSC																								
	DANGLE																								
	CHAIR														✓										
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE														✓										
	HOB 30 DEGREES			✓				✓			✓				✓									✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)								✓			✓				✓										
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)			✓																					
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended							1 SOFT			1 SOFT				1 SOFT									1	
BOWEL SOUNDS (active all quads)								HYPO			HYPO				HYPO									X	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.								✓			✓				✓									✓	
SKIN INTEGRITY	No Breakdown							✓			✓				✓									✓	
	Surgical Wounds																								
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)								✓			✓				✓									✓	
#1 LUE								SS			SS				SS									✓	
#2 LLE																									
#3																									

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18g	(R) Hand	25Sep03 0700/03	patent, ~~0~~ erythema, edema, phlebitis
16g	LEJ	25Sep03 1430 25Sep03	Patent & S/Sx of infection or infiltration
			" " "

(b)(6)-2

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (3) To Voice (2) To Pain (1) Does Not Open								4			4				4									4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response								5			5				5									5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (5) Localizes to Pain (4) Withdraw to Pain (3) Flexion to Pain (2) Extension to Pain (1) No Response								6			6				6									6	
GLASGOW COMA SCALE (A+B+C)								15			15				15									15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R														+2										
	L														+2										
MOVEMENT (See Motor Function Scale at Top of Page)	RUE							4			4				4									4	
	LUE							3			3				3									3	
	RLE							4			4				4									4	
	LLE							2			2				2									2	
GRIP (S) Strong (W) Weak (-) absent	R							5			5				5									5	
	L							N/A			N/A				N/A									–	
RESPIRATIONS	REGULAR							✓			✓				✓									✓	
	IRREGULAR																								
	UNLABORED							✓			✓				✓									✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL							5			5				5									5	
	LUL							5			5				5									5	
	RLL							5/1			5/1				5/1									5	
	LLL							5/1			5/1				5/1									5	
	BOTH BASES							5/1 ✓			5/1 ✓				5/1									5	
COUGH	NONE							✓							✓									✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)							3L			5L				5L									2L	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS																									

(b)(6)-2

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100																	
0200																	
0300																	
0400																	
0500	102.6	117	22	117/70	94												
0600																	
0700	102.7 (A)	114	32	117/70	95												
0800	102.4 (A)																
0900	OR →																
1000	100.1 (A)	112	16	119/78	91%												
1100																	
1200	101.5 (A)	114	16	117/71	92%												
1300		111	15	117/72	93%												
1400	101.9 (A)	109	18	121/88	100%												
1500																	
1600	102.9 (A)	111	18	116/71	97%												
1700	101.5 (A)																
1800	100.6	107	18	120/72	97%												
1900																	
2000	99.5	101	15	111/70	94%												
2100																	
2200																	
2300	100.7	101	18		97												
2400																	

	INTAKE									OUTPUT						
	DSW/Cable	IVM	LR						Total	Urine	Stool	NG			Total	COMMENTS
0100	100/100															
0200	100/100	50/50								200/200						
0300	50/250															
0400	100/350									250/450						
0500	100/450									220/670						
0600	100/550											100/100				
0700	100/650	50/100								200/~~200~~ 870						
0800	100/750															
8 HR	750	100							8 HR. 850	890		100			8 HR 990	-140
0900	100/100	50/50														
1000	OR —		800/800													
1100	100/200	50/100														
1200	100/300	250/350														
1300	100/400	50/400														
1400	100/500											50/50				
1500	100/600															
1600	50/650	50/400								500/500						
8 HR	650	400	800						16 HR. ~~1400~~ 2750	1390		50			16 HR. 2430	
1700	100/100															
1800	100/100	100/100								500						
1900	100/200															
2000	100/300															
2100	100/400															
2200	100/500															
2300	100/600															
2400	50/650	50/150														
8 HR									24 HR.						24 HR	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Sep 03 0045	0045		Pt linen changed, washed pt after scant liquid stool, no substance in stool allowed pt to rinse & spit. Tolerated entirety of procedure well. (b)(6)-2
	0310		Pt c̄ c/o pain, unable to get clear numeric rating ~~through~~ through interpreter. Repositioned for comfort at present. (b)(6)-2
	0520		Pt sitting in high fowler, leg repositioned. Falls drawn. will monitor. (b)(6)-2
	0530		Medicated for T (O2) & (A). Linen change tolerated well. (b)(6)-2
3Sep 03	0700		Portable KUB done. NAD (-) c/o discomfort. USS Temp 102.7. Will continue to monitor. (b)(6)-2 LT, RN
3Sep03	0850		TO OR via Litter. NAD noted. (b)(6)-2
3Sep 03	1000		RTD from OR see CC flowsheet & PACU flowsheet. (b)(6)-2 LT, RN.
3 Sep 03		1225	Medicated c̄ Tylenol 650 mg PR for temp 101 (b)(6)-2 LT, RN
3Sep03		1500	Pt moved back to bed tolerated transfer WELL. Resting quietly @ this time (b)(6)-2
"		1600	Pt medicated c̄ 1gm Tylenol as per MD. Temp 102.6 (b)(6)-2
"		2130	MD to D drsg. V→D drsg c̄ wound packing replaced. Pt tolerated procedure well (b)(6)-2
		2200	Assumed care of pt, @ distress, repositioned for comfort. (b)(6)-2
		2300	Assessment per flowsheet, (L) BJ site ≅ S/S of infiltration, Replock to (R) hand patent also ≅ S/S of infiltration. abd remains distended c̄ hypoactive bowel sounds. NGT retaped. Placement verified via aspiration and auscultation. (b)(6)-2

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4

(detainee)

(b)(3)-1

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER (b)(6)-2

25. TYPE DISPOSITION: D/C

26. DATE OF DISPOSITION: 29 Aug 03

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

war wounds

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

(1) open (R) Thumb P1 fx & mc fx 817.1 ICD9.02

(2) open (R) Tibia fx 823.90 ICD9.02

(3) multiple (L) & (R) LE open wounds c̄ retained Shrapnel E991.9 ICD9.02

(4) open (L) Knee 891.0 ICD9.02

(5) (R) Thumb EPL/ac (R) foot ~~EHL~~/ac

(6) I&D wounds / open arthrotomy (L) Knee

(7) Pinning (R) Thumb / (L) 2nd mc

(8) Ex Fix (R) Tibia

☐ CHECK IF CONTINUED ON REVERSE

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

36. TOTAL DAYS ALL FACILITIES

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

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2

SIGNATURE OF PATIENT MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 1 MAY 79 3647-1 EDITION OF 1 AUG

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

Iraqi male now 48 hours out from fight c̄ apache Helicopter
Tx'ed @ Iraqi hospital. Referred c̄ multiple wounds (L) & (R) LE
(R) LE. Radiographs reveal open (R) Tibia fx, open (R) Thumb
MCPJ c̄ fx's P1/MC, and soft tissue defect (R) calf
c̄ ? fx (L) Tibial plateau

PMH PSH meds

PHYSICAL EXAMINATION

(PE) open (R) Thumb @ MCPJ
open (R) Tibia fx
open wounds (L) & (R) LE's

(A):

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

(P) (1) I&D extremity wounds
(2) Pinning (R) Thumb MCP P1/MC fx
(3) Ex-Fix (R) Tibia
(4) Remove Shrapnel

(b)(6)-2	DATE 7/20/03	IDENTIFICATION NO.	ORGANIZATION
TION (*For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility*)		REGISTER NO.	WARD NO.

Iraqi (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.806-8
OCTOBER 1975 539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

op-note

Pre-op Dx: ① open ® Tibia fx
② open © Knee
③ open © foot and MT fx
④ open ® Thumb proximal phalanx +
(b)(6)-2
⑤ ® foot EHL lac
⑥ ® Thum EPL lac
⑦ multiple © + ® LE + ® UE wounds

Procedure: ① I + D all wounds
② open arthrotomy © Knee
③ ex-fix ® Tibia
④ Pinning © foot and MT fx
⑤ Pinning ® Thumb MC / proximal phalanx
(b)(6)-2

GEN

ABL 1000 cc crystals

(b)(6)-2

To PCR in stable cond

(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.

Frag.

(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

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

Op-note

7/28/03

Pre-op Dx: open (R) Tibia fx c̄ EHL lac
Post-op Dx open (R) Thumb fx c̄ EPL lac
open (L) Knee

Procedure: I&D (L) & (R) LE & (R) UE
Repair EPL,
wound closure / Adjust Ex

Thurst Phillips, Sam Sam, Brisamela
EBL min
TTTQ
TCTR instable Cond

(b)(6)-2

MD

30 July 03 Preop/Postop Dx: open (R) thumb fx c̄ EPL lac
open (L) foot 2nd MT fx

Procedure: (R) AKBG to (R) thumb and (L) foot
I&D (R) LE; skin flap (R) hand
wound closure

(b)(6)-2, (b)(6)-2, (b)(6)-2 anesthesia (b)(6)-2 (b)(6)-2

EBL 100cc Fluids 800cc UOP NM Foley

(b)(6)-2

Complications: Pt c̄ SV, US WNL

(Continue on reverse side)

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

Iraqi # (b)(6)-4

REGISTER NO. (b)(6)-2 WARD NO.

LTC (b)(6)-2

PROGRESS NOTES
Medical Record

MEDCOM - 1374

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD — PROGRESS NOTES

DATE

2003 OMNONOTE

3/30/1 POD #1 S/P (R) AMCBG to R/ hand, by Pt... Adx: Ancef.

2030 S/ Pt seems to be doing better c̄ less narcotic requirement IV. morphin and tylox - works well. PO intake OK but not full meals. c/o pain (L) leg

O/ T m 100.2 at 1400 tid to 99.5 c̄ IS. P= 80's - 105 BP WNL

Resting quietly.

Earlier in day, (R) hand dressing removed - viable skin flap, no necrotic or dusky edges. Good position of digits ∅ s/sx infex (L) foot good alignment and all incisions/lacs c/d/i s̄ s/sx infex. Splint placed on foot/leg.

(R) tib ex fix in good alignment s̄ s/sx infex at pin sites - tissue healthy. Hyp dressing intact/dry CV RRR lungs CTAB Abd soft NTND

Plain films reveal good alignment of bone grafts to (R) thumb, (L) 2nd MT good position of ex fix.

A/ S/P (R) AMCBG to (R) thumb and (L) foot in addition to ex fix - multiple lacs, tendon repair since 26 July. Doing well s̄ s/sx of infection and continued viability of hand skin flap.

P/ continue present mgt c̄ newly placed splint (L) LE, dressing changes, wound care. will encourage IS, po intake & OOB.

(b)(6)-2

(b)(6)-2 LTC DDS USN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE 2003

3 aug ortho note

POD #4 s/p (R) ATCHA to (R) hand / (L) foot c̄ skin flap

no major complaints x̄ some paresthesia of (L) toes (2nd, great) x 2 days

Family food brought in and using incentive spirometry and supplementing diet c̄ Ensure. Has been OOB more the last few days. wounds cleaned / dressed bid

AF VS CNL

A/O bright, enthusiastic moving well.

all abrasions / lacs are healing well c̄ clean margins, good granulation, gd suture approximation. Skin flap viable on (R) hand (R) inp harvest site c̄ intact steristrips & hematoma, serous

(L) great toe can feel pressure, pinching, moderate touch

(L) 2nd toe not feeling pinch / light touch

(L) LE in cast

Assessment / Healing well p̄ major trauma to (R) UE (hand), (R) LE c̄ (R) UE ex fix, (R) hand skin flap, bone graft to thumb, (L) foot bone graft, tendon repairs - No S/Sx infex tmcl and of (L) toe paresthesia. granulating skin flap donor site - tendon areas s̄ epithelial covering

Plan CPM, cont. to dress wounds

Plan suture removal and anticipate skin grafts

(b)(6)-2

(b)(6)-2

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

[illegible] Aug 03 Nurses report one' [illegible] - loose BM yesterday
1100 & another this [illegible]

(b)(6)-2

Lieutenant Col (b)(6)-2 Corps
Chief, Department of Medicine

2003 ortho op note

Sang preop/postop DX: (R) LE ex fix, tendon repair
(R) hand bonegraft, skin flap potential infection/wound edge dehiscence; macerated tissue

Operation: (R) hand skin flap modification, debridement, repair
(R) LE debride/irrigate

(b)(6)-2 / (b)(6)-2 / (b)(6)-2 EBL min Fluids · see anesthes

Findings: good granulation (R) hand donor site. No purulence around bonegraft / cortical + cancellous grafts intact. Debrided wound edges. 3.0 nylon to approximate - good approximation

Dressed c̄ sterofoams, fluffs, Kerlix

Tolerated well. Extubated c̄ difficulty TO PACU / ICU c̄ SV, VS stable

1g IVPB Ancef

(b)(6)-2

(b)(6)-2 [illegible]

6AUG03 0800: T=98', P=76 R=16, BP=115/50, sat=98. PT refuses breakfast - will offer Ensure in 1-2 hrs. Denies pain - c/o ace wrap (R) LE tight - re-wrapped +

(b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

Sragi (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
6 AUG 03 0800	cont performed dressing Δ. PT states ⓟ leg feels better now. Pulses good (DP) bil. VSS. Will defer Ⓡ hand dressing Δ to physicians since this is the first dressing Δ since surg yest. (b)(6)-2
6 AUG 03	1000 - (b)(6)-2 did Ⓡ hand dressing Δ. Will use Xeroform dressing to graft site, dry gauze between thumb + 1st finger - then Kerlex wrap.
(b)(6)-2	PT drank 1 can Ensure + ate 2 cookies. (b)(6)-2
06 Aug 03	Assumed care of dressing. VSS - afebrile No ⓟ pain. Cont monitor. - (b)(6)-2
2000	surgeon note
6 Aug 03	s/p multiple ortho procedures, ex fix, modify skin flap.
	PT still picky c̄ eating - will do Ensure and family bringing food.
	VS WNL AF
	Removed Ⓡ hand dressing - macerated web space. ⓟ necrosis or dehiscence - bone graft covered. (+) sensation to digits (c/f slightly less light touch)
	Dressing Δ c̄ xeroform, dry gauze, kerlex bid (done c̄ ↑ chevroni)
	Ⓡ LE ex fix intact, pins 5 8/cx infex. Ⓛ LE 2nd digit ↓'d sensation c/w initial injury (also where bone graft placed) no injury) cast OK fit, NV intact. ⓟ s/cx infex. Hip flex intact. Sensation intact.
	A) PT doing well - Ⓡ hand flap revision ortho. web space macerated pending skin graft for tendon covering
	P) continue wound care. will d/c w/d to avoid maceration will continue to observe for dehiscence/wound breakdown anticipate skin graft before d/c (b)(6)-2
	(b)(6)-2

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE	
6 Aug 03 @ 1200	Refused lunch initially, however, requested food & threw away. Provided soup & MRE - refused. ½ can ensure consumed - interpreter and physician discussed nutrition. Monitor. effect of teaching (b)(6)-2
6 AUG 03 1715	Pt consumed approx 95% of evening meal without incident or difficulty. Voided 400 cc clear yellow urine. Resting comfortably @ this time. SSG (b)(6)-2
6 AUG 03 1800	PT c/o pain to (R) LE. Administered 1 Tylox. Will [illegible] effectiveness. SSG (b)(6)-2 LPN.
6 AUG 03 2000	Assessment completed VSS. 113/54 T. 99' R 16 P 87 Pox 96% RA. ZANTAC GIVEN. Dressing changes to (R) LE & (R) HAND completed. Tolerated well. Resting @ this time. Will continue to monitor SSG (b)(6)-2 LPN
6 Aug 03 @ 2200.	Rec'd report and assumed care of Pt. VSS - afebrile. No c/o pain @ this time. Dressings c/d/i; SL - (R) Harm flushed c̄ NS - patent: site c/d/i. ~ Pt d/c'd 2° 3d placement. 20ga SL initiated (R) Harm - patent - c/d/i. Interpreter called - Pt. c/o slight numbness (R) LE. Physicians aware - cont. mon. for. Currently eating food brought in by interpreter. Cont. mon. (b)(6)-2
6 Aug 03 2300 121/56 -85 99' - 16 @ 0025	Pt. c̄ PCA therapy infusing c̄ s/s of complication. Consumed a "meal's worth" of food provided by interpreter ~ vegetables/breads (b)(6)-2 Pt % pain @ achilles area - (R) LE. Dressing removed, wet/dry d'd and gauze and kerlix wrap reduced in order to prevent pressure. Interpreter assisted c̄ communication. Cont. mon. (b)(6)-2
@ 0400	No d'c's - Pt has been sleeping c̄ s/s of acute distress. (b)(6)-2
7 AUG 03 0700	Assumed care of pt. Vital signs: BP 113/62 HR 89 Temp 98.7 Pulse ox 94% Resp 14. Assessment complete, brisk cap refill on upper extremities, popliteal pulses normal, cap

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
Cont.	refill on lower extremities brisk. Pt complaining of pain under cast on LLE. Motrin 800mg PO given as ordered.
7 AUG 03	Dressings on extremities C, D & I. Pt complaining on pressure/throbbing in (L) FA IV site. Site was patent and without sign of infiltration. Heplock was flushed. Lung sounds clear, S1 and S2, bowel sounds active. Asked doctor if Heplock can be DC'd and pt put on PO antibiotics – denied. Will place a new Heplock site on (L) FA, due to pt discomfort and ancef running very slowly in current heplock. SPC (b)(6)-2
7 AUG 03 1251	Assisted Dr. (b)(6)-2 in removing LLE cast and some of the patient's stitches from wounds on LLE and (R) shoulder. Dr. will remove remaining stitches at a later date. SPC (b)(6)-2
7AUG03 1430	Pt assessed @ this time. Wounds on upper body healing well. Lungs CTA bilaterally, BS x 4, HS – S1/S2, Pt drsgs on RUE, LLE, RLE C/D/I. RLE Drsg to be Δ'd by nursing staff. (b)(6)-2 VSS – BP 107/69, HR 99, T – 99.4, R – 16, O_2 Sat – 95%.
7AUG03 2030	Drsg Δ to RLE completed. Wound looks red and beefy c̄ minimal exudate present. Pt tolerated W→D Δ well. However, had 2 tylox prior for complaints of pain in LLE. MD aware (b)(6)-2 CAA
7Aug03	V/S areas follows: HR: 99 RR: 16 B/P: 103/52 Temp: 98.7 O_2 Sat: 95% Pt assessment as follows, Pt is A+O x3 PERRLA (B) hand grip strength is strong. Pt is able to wiggle all fingers and toes. Pt's has RRR pulses are strong in (B) UE, cap refill <2 sec x 4 extremities. Pt is ~~c~~ pain free this time. Will continue to monitor. SPC (b)(6)-2 SPC LVN

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

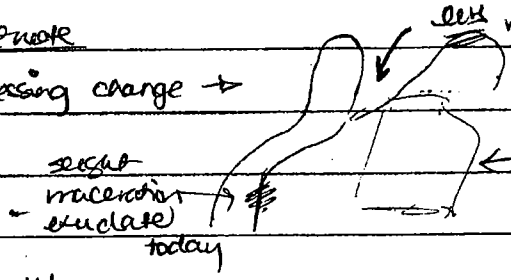
DATE

2003 2 aug

antibiotic note

(R) hand dressing change →

less maceration than 2 days ago



(b)(6)-2

will d/c IV antibiotics and change to po clindamycin for time being.

1430 BAU 403 Pt VSS: BP 86/45, HR 92, T-99.3, O_2 sats 96%, R-12. Pt took 1 can of ensure. Had loose stool approx 300cc. Pt drsg on RUE, RLE, LLE are CDI @ this time. Physical exam other than lacerations/drsg unremarkable. (b)(6)-2 CPT Kay

2030 BAU 403 W→D drsg Δ to RLE. Pt tol. well and assisted c̄ pain care. Wound appears beefy, red c̄ minimal exudate. W→D drsg reapplied; c̄ splint (b)(6)-2 CPT AN

8/9/03 operative

Pre/Post op Dx: Infected @ Thumb fasciotomy
Infected @ foot graft

Procedure: Remove grafts / I&D
Antibiotic cement spacer @ thumb
L. wound closure

(b)(6)-2 [illegible] space of TCR
in stable condition

(continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; hospital or medical facility) (b)(6)-2 WARD NO.

Iraqi # (b)(6)-4 Prevs

PROGRESS NOTES
Medical Record

MEDCOM - 1381

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

509-113 NSN 7540-00-634-4122

MEDICAL RECORD	PROGRESS NOTES
DATE 8 AUG 03	
0700	Vital signs: HR-106 BP-115/59 Temp-99.1 PulseOX-95% Resp-14 Assumed care of pt. SPC (b)(6)-2
8 AUG 11:35	Pt has had diarrhea x2 this morning. He requested meds, however Dr (b)(6)-2 says if diarrhea continues he will prescribe meds. Dressing on (R) leg changed as ordered. Small amount of bloody drainage and tissue by achiles tendon looks white today. Dr. changed (R) hand dressing And will change (L) leg dressing tomorrow. Assessment complete, vital signs normal, brisk cap refill, pt experiencing numbness in (L) leg. Doctor states is normal for injury. Abrasions and lacerations Appear to be healing well. Bowel sounds active x4, clear lung sounds, S1 and S2 heart sounds, ∅ pain. SPC (b)(6)-2
8 Aug 03 2245	Vital signs are as follows: HR-100 RR-12 BP-103/49 Temp-99.3 O2 Sat-9[illegible] Pt report received. Pt is A+O x3, PERRLA and pt is able to move all extremities. Pt c/o no pain, but ~~does~~ DPT does c/o numbness to the toe next to the great toe on (L) foot and pt has very little strength to that toe. Pt has also c/o slight numbness to (R) index finger, strength is appropria[illegible] (R) hand grip strength strong and cap refill <2sec ± 2+ radial pulse. Cap refill for all extremities <2sec. Will continue to monitor. SPC (b)(6)-2 SIC LVN
8 Aug 03 2340	(Late note) Dressing ↑ done per Dr (b)(6)-2 instructions. Wound is dark pink and meaty. 6 inches of Kerlex moistened then squeezed damp (cont.)

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last; first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PROGRESS NOTES

DATE	
8 Aug 03 2348	(cont.) placed over wound and Dry Kerlex was wrapped around pt's hand. Dressing secured c̄ 2" silk tape. Will continue to monitor. — SPC (b)(6)-2
9 AUG 03	
0700	Assumed care of pt. Vitals: BP - 109/68 HR - 101 Temp - 97.7 Pulse ox - 96% Resp - 14. Assessment complete, lung sounds clear, S1+S2 heart sounds, bowel sounds Active x4, pt had diarrhea x 1 today, Dr. (b)(6)-2 changed (L) foot and (R) hand bandages, nursing staff changed (R) leg dressing. Wound looks red and meaty. Pt to Surgery @ 1500 for (R) Hand washout, NPO after 0800 breakfast. IV started in (L) FA, 18 g, patent and ⊖ sign of infiltration. IV Ancef prescribed and given as ordered. Pt reports ⊖ pain. SPC (b)(6)-2
1400	assumed care of pt. sitting up in bed, ⊖ distress VS: 106/60, P 96, R-16, T-99.2 SaO2-95. Pt NAD, ~~Alert~~ Alert & cooperative. Lungs CTA (B), ⊖ W RR heart RRR, S1 S2 ⊖ murmur or rubs Abd soft & flat, (+) BS x 4 q. ⊖ masses, tenderness or organomegaly ⊖ BS. peripheral pulses 2+ (B) UE & LE. (+) strength & ROM all extremities. ⊖ drainage to drsg on wounds (b)(6)-2
1450	Pt to OR. Pt with Commode stool x 1. ⊖ distress noted. linens changed on bed. (b)(6)-2
1620	Pt to bed. see Postop note. (b)(6)-2
1735	Pt awake, offered food. pt refused. (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/20101

STANDARD FORM 509 (REV. 7-91) BACK

PROGRESS NOTES

DATE	
9Aug03 2220	Pt report received. Pt is A+O x3 PERRLA (L) hand grip strong. Pt is able to move all ~~finger~~ (b)(6)-2 fingers and toes. Cap refill on all fingers and toes is <2sec. Pt c/o pain to (L) Lower Leg and (R) hand. Pt medicated c̄ II̅ tylo. Will continue to monitor. SPC (b)(6)-2 9c LVN
10Aug03 0315	VS are as follows: HR-82, RR-16, BP-113/69, Temp-99.2°, O2 Sat-94% on RA. Will continue to monitor. SPC (b)(6)-2 9c LVN
10AUG03 0800	Assumed care of pt. Vital Signs: Temp-97.3°, Resp-14 HR-95 BP-115/62 Pulse Ox-94%. SPC (b)(6)-2 WMC
10AUG03 0900	Assessment complete. (R) LE needed one more Steri Strip applied by doctor due to separation of remaining stitches on top surface of foot. (R) heel wound looks red and meaty. Overall appearance of skin was dry and scaling so lotion was applied after bed bath. @ 0830 output of 825cc urine, light yellow via bedside urinal. Cap refill <2 seconds in all extremities, pulses normal, lung sounds clear, S1+S2 heart sounds, pt complaining of itching on 2LE, no complaints after lotion applied. Pt reports ∅ pain. Bowel sounds present x4. SPC (b)(6)-2 9c WMC
10Aug03 1100	Concur c̄ above assessment (b)(6)-2
10AUG03 1300	Dr. (b)(6)-2 to change dressing tonight only - due to surgery yesterday - no morning dressing change. Pt had output of 450cc urine, clear and light yellow. Pt complaining of (L) leg + (R) hand pain. 2 Tylox given as ordered. IV running LR @ 60cc/hr to (L) FA, patent and ∅ sign of infection. Pt drinking plenty of PO fluids. SPC (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
1930 10AUG03	Pt assessment complete. VS 109/54, HR-89, Pulse Ox-95%, Temp 99° (o). Lungs CTA Bilaterally, HS-S1S2, BS x 4 quads, IVF @ 60cc/hr (L) FA. Pt consumed 90% of evening meal. Drsg on (L) hand and both lower extremities C/D/I. Drsg Δ to be completed this evening to RLE — (b)(6)-2
2030 10AUG03	Pt drsg's changed on URE/~~RLE~~. Both wounds appear red and beefy ī minimal exudate on ~~RA~~ (b)(6)-2 LE also ī sanguinous drainage. Both drsgs replaced as per MD instructio (b)(6)-2
2230 10AUG03	VS: 98/37 T 99.5 P 95 96% RA R 15 LR infusing @ 60cc/hr into (R) FA, site patent ~~o~~s/sx infection/infiltration. Lungs CTA (B) Cardiac S1S2 ī murmur BS Active x4 peripheral pulses +2 in all extremities. (LLE, RUE, LUE) Pt c/o itching to lower extremities. Dressings CDI. — (b)(6)-2 LTAW
11 AUG 03 0700	Assumed care of pt. Doc ordered NPO, possible skin grafting today. Output of 500cc medium yellow urine. Vital signs - BP 109/55 HR 97 Temp 98.8 Pulse ox 96 Resp 12 (R) leg wound looking white near stitches on Achiles tendon, other areas more red with bloody drainage during dressing change. Pedal pulses normal, LUE normal radial pulse, RUE bandage is C, D, + I. Cap refill brisk in all extremities, lung sounds clear, S1 + S2, bowel sounds active x4. LR infusing @ 60cc/hr to (L) FA, patent and sign of infiltration — SPC (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

Iraqi (b)(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
Continued	
11 AUG 03 0820	Pt told several times not to pick at scabs. Pt reports ∅ pain, however complaining of abdominal discomfort ∅ diarrhea. —— SPC (b)(6)-2 WMC
11 AUG 03 0900	Dr. (b)(6)-2 said pt will not be getting skin graft today, pt no longer NPO —— SPC (b)(6)-2
11 AUG 03 1320	Assisted Dr. (b)(6)-2 with (R) Hand + (L) Foot Drsg A's. Skin grafting may take place on Wednesday. No complaints and ∅ pain, pt had diarrhea x 1 @ 1100 hrs. SPC (b)(6)-2
11 Aug 03 @ 1430	Rec'd report and assumed care of Pt VSS-afebrile. Dressings c/o/i. No c/o pain
99.4-80-110/56 18	@ this time. PIV ē LRC 60/hr - (R) AC - ē S/S of complication. Cont. mon. tx. — (b)(6)-2 CN
@ 1830	Pt. consumed an approx. 40% of evening meal, and drank .5L bottle of gatorade. Has remained ē complaint. IVB and currently infusing — (b)(6)-2 LPN —
Addition:	Void. via urinal: 500cc c/y urine. — (b)(6)-2 LPN —
@ 2150	Dressing A to (R) RE - Wet-to-Dry per order. Red/Healing looking tissue ē two areas approx 5mm-6mm ē slight purulence. Voided 350 cc c/y urine. Medicated for c/o pain (verified by interpreter) ē Tylox x II. Report status to on-coming shift. — (b)(6)-2 LPN —
12 AUG 03 0800	Assumed care of pt, VSS and afebrile. (R) Hand dressing
97.2, 82, 113/58 14	has serous drainage on bandage, to be changed this AM by Dr. (b)(6)-2 (R) LE Drsg changed, site looks very good, the wound is approximating and color is good. ADL care complete w/ Assistance, bedding changed today. Pt used bedside commode, loose stool with 500cc light yellow urine. Lung sounds clear, S1 and S2, normal radial and pedal pulses and capr refill is brisk. ∅ complaints, ∅ pain, pt eating a good breakfast of fruit and MRE. SPC (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	
12 AUG 03 0900	Drsg Δ by Dr (b)(6)-2 (R) thumb needs washout. NPO until surgery later this afternoon (1500hrs). — SPC (b)(6)-2
12 AUG-03 0915	Interpreter explained to pt that (R) thumb will be worked on in surgery, NPO until after surgery. Interpreter gave pt 2 bags of food, soda, and cookies from pt's family (b)(6)-2
12 Aug 03 @ 1430	VSS-afebrile. Assessment completed. Dressings c/o/i. Pt. remains NPO 2° scheduled surgery. No complaints @ this time. Cont. monitor. (b)(6)-2
994-16 117/38-56 12 Aug 03 1650	Pt. recovered from procedure. S/P Washout (R) Hand. Pain controlled c̄ MSO4 during recovery (See PACU Flowsheet). Administered Tylox ii PO for further c/o pain upon completion of recovery. Dressings remain c/o/i. Post op Cont. monitor — (b)(6)-2
@ 1800	Pt. tolerated food brought by interpreter. Currently resting c̄ c/o/d acute distress. (b)(6)-2
2120	I concur c̄ above assessment (b)(6)-2
12 Aug 03 2220	VS areas follows: HR-85 RR-16 BP-116/57 Temp-98.3 O_2 Sat-97% Pt is A+O x3 PERRLA, pt is able to move all fingers and toes. Pt has RRR pulse is 2+ in (L) UE capr fill is <2 sec. Pt is c̄ pain to (R) hand. Pt medicated c̄ ii tylox. Will continue to monitor. — SPC (b)(6)-2
12 Aug 03 0235	pt resting will cont to monitor (b)(6)-2
0230	Pt. consulted Sgt (b)(6)-2 stated she will be in this afternoon for stretches and getting him to chair will cont to monitor (b)(6)-2

(Continue on reverse side)

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MEDICAL RECORD | PROGRESS NOTES

DATE	
13 Aug 03 0920	1020 ~ @ 0930 Dr (b)(6)-2 in @ BS to Δ dsg to (R) hand.
BP - 116/57	~~w~~ dsg to (R) LE Δ^ed ~~at home~~ (b)(6)-2 wet → Dry, pin care
P - 85	completed. lung ~~sounds~~ assessment CTA, pulses
R - 12	+2 ped + rad. pt had BM c̄ urine this AM. Stool
T - 99.3	was soft & non formed. cap refill brisk. pt
	refused Breakfast. Interpeter brought in food.
	IV Δ^ed in (L) FA. patient ~~+~~ AOI. Dsg Δ^ed to (R) foot
	sm ~~amount~~ amt of drainage to stitches. Non adhesive
	dsg placed, DSA, will cont to monita (b)(6)-2
13 Aug 03 1300	PT note: pnt. is Iraqi male c̄ multiple wounds - Ex. Fix (R)
	LE Tib/Fib/ankle & wounds to (R) ankle. % N/T
	in (L) LE down to toes. pnt has wound to (R)
	hand - skin flap - unable to use thumb.
	pnt. instructed (thru interpreter) in ex. program for bed activity.
	: Quad sets x 10 reps c̄ 3 sec. hold (B) LE q 3°,
	SLR's 10 reps c̄ 3 sec hold (B) LE q 3°, ankle pumps
	and ankle circles (L) ankle x 10 each q 3° - wiggle
	toes (B) and II - V digits (R) hand throughout the
	day. pnt. ambulation status in question -
	WB status for (R) LE ex. fix ? & (R) hand expressly
	(R) thumb. Status for WB through it for use of
	crutches? therapist will consult Dr. (b)(6)-2 &
	return for further ambulation coaching. will
	progress pnt. c̄ ~~exercises~~ & WB/ambulation as
	permitted.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, hospital or medical facility) (b)(6)-2 (b)(6)-2 WARD NO. MPT/SGT/91WM9

Iraq (b)(6)-4

PROGRESS NOTES

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PROGRESS NOTES

DATE	
13 AUG 03 1430	Recieved Pt VSS = oral temp 99.4, RR 14, HR 99, BP 102/55 O2SAT 99% RA, CTA X5, BSA X4 Quads, Peripheral pulses Strong equal Ø Complaints at this time Will continue to monito (b)(6)-2 sgt 91WM6
13 Aug 03 2225	Received pt. VS areas follows: HR-81 RR-16 BP-109/56 Temp-99.2 O2Sat-96%. Pt is A+O PERRLA grip strength strong on (L) UE, pt can move all fingers and toes. Capre fill <2 sec x4 extremities Pulses 2+ x (B) UE. Pt is c/o pain. Will continue to monitor. SPC (b)(6)-2 91C LVN
14 AUG 03 0800	T=98.6, P=89, R=12, BP=98/52, sat=99 on RA. PT awaken for VS + assessment. PT refuses breakfast + am care. Cardiac - RRR S MRG, Lungs - CTA, BS actively, Pulses at Bil - DP (L) + radial. (R) DP can't be assessed due to dressing. Good cap refill. Skin warm + dry. IV LR @ 60 cc/hr. in (L) FA S S/S of infection or infiltration. Dressing (R) hand - small area of serous drainage. (R) LE - ex. fix. remains in place as well as splint + wrap. (b)(6)-2 MOT
0945	- PT OOB to chair - transferred himself S diff. (b)(6)-2 MOT
1500	Recieved Pt VSS = 99.1°, HR85, BP 100/58 RR16 SAO2 98% RA, CTA X5, BSA X4 Quads peripheral pulses +2 Equal strong Ø complaints at this time will continue to monitor (b)(6)-2 SGT 91WM6 LVN
2200	Pt UOP = 1200 cc This shift (b)(6)-2 SGT 91WM6 LVN
14 Aug 03 2235	Pt voided 425cc of clear yellow urine. Pt is A+O x3 PERRLA (L) UE grip strength strong. Pt can move all fingers and toes. Capre fill is <2 sec x4 extremities. VS are as follows: HR-94 RR-16 BP-105/48 Temp-99.0 SaO2 98%. Will continue to monitor. SP (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE 15 AUG 03	Assumed care of pt. VSS, afebrile. Lung sounds
0720	clear, S1 and S2, bowel sounds active x4, pt
98.4°, 98%	refused breakfast. Bandages C, D, + I, brisk
85 HR, 107/59	cap refill, LR @ 60 cc/hr to (D) FA, patent and ∅ sign of infection. SPC (b)(6)-2
14 Resp	
15 AUG 03	
0750	Pt had loose stool x1 and 575 cc Medium yellow urine. SPC (b)(6)-2
15 AUG 03	
1005	Pt complaining of dry, flaking skin on scalp. Morning
	Care Complete, Drsg Δ's as Ordered. No drainage on
	dressings, wounds looking good SPC (b)(6)-2
15AUG03	Pt Assessment complete. VS - BP 107/61, HR - 89, T - 98.8, O2 - 98%,
1430	R - 16. LS - CTA B/Lat., HS - S1/S2, BS x4 quads. NEURO VS WNL. IVF
	HLed as per MD order (b)(6)-2
2110	Pt UOP - 700cc for shift. Drsg Δ's on RUE, RLE, LLE complete
	wounds c̄ mod. exudate / appear red and beefy (b)(6)-2
15AUG03	VS: 98.5, 102/55, 81, 98% RA R 18 Pt AOx3
2330	Lungs CTA (B), heart RRR s murmur, BS Active x4 IVin (D) FA
	flushes well ∅ s/s infection/infiltration. Pt neuro vasc. ✓ WNL
	on RUE, and (B) LE. Pt resting in bed (b)(6)-2
16Aug03	
0730	lung assessment CTA, A+Ox3 BS(+) 4q flex + Extension
BP 107/62	(B) LE not full strength pulses +2 (B) LE + (B) UE, drsg
P 78	Δ'd W→D on (R) LE. (L) foot drsg Δ'd. Bacitracin
R 18	+ non adhesive drsg applied. Bath complete
T 98.8°	will cont to monitor (b)(6)-2
O2 99%	

(Continue on reverse side)

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Frag (b)(6)-4

PROGRESS NOTES
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DATE	
1040 16Aug03	@ 0900 pt has sm watery BM c̄ urine ↑ to BSC. pt ate late breakfast Early lunch. (interpeter brought in meal. will cont to monitor (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE 2003

16 Aug

ORTHO PROGRESS NOTE

HD # 22 (2 Aug 03) s/p multiple ortho injuries / operations

issues: skin graft (R) hand, (R) LE (over tendon)

strengthening exercises quads

nutrition

ex fix (R) LE

multiple healing wounds - sutures, scar tissue, (also s/p bone graft removal (R) hand, (L) foot 2° infection)

? (R) thumb retention vs. amputation

remains AF, VS WNL

pt has consulted c̄ pt and pt has ↓ doing exercises per her recommendation.

interpreter brings pt meals; apparently throws some food away - but is eating better through day - will recommend supplement c̄ Ensure

wounds daily dressed - ∅ c/o infection currently since PMMA/vanc (cement) placed 12 Aug 03 - No fluctuance, no purulence / exudate expressed.

doing well currently c̄ (R) LE ex fix, bone graft removal from infected (R) hand, (L) foot c̄ placement of 2nd vanc bone cement (PMMA) to (R) thumb. Sites healthy red and healthy for skin graft. (R) thumb / hand currently s̄ infex.

will continue to follow, monitor dressing Δ's / inspect wounds / push nutrition + exercise

Pending skin graft

(b)(6)-2

(b)(6)-2

(Continue on reverse side)

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

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WARD NO.

IRAQI (b)(6)-4

PROGRESS NOTES

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MEDICAL RECORD	PROGRESS NOTES
DATE	
16AUG03 1400	Assumed care of pt, NAD, awake waiting T.V. VS - T 98.6 P 89 BP 109/58 R 20 Lungs CTA, RR. Heart RRR, abd soft, flat (+) BS x4 quads skin warm dry intact. Moves ext. x4 (=) = 5/5 strength (B), neurovascular check intact. dsgs dry & drainage. IV (L) FA patent, & infl or edema (b)(6)-2
1700	Pt eating dinner, (-) distress noted (b)(6)-2
1910	Pt c̄ % pain to (R) LE. Medicated per order. (b)(6)-2
2120	Dsg Δ performed, pt tolerated well. good granulation tissue noted (b)(6)-2
16AUG03 2215	VS - T=97.8, P=80, R=16, BP=110/60 Sat=98% on RA. PT denies pain. Assessment complete - VSS, cardiac - RRR & MRS, Lungs CTA, ABD - BS x4 - (-) TTP - Dressings (R) hand, (L) foot, (R) LE CDI. Ex fix remains in place (R) LE - Able to all extremities - good strength, good cap refill. HL (L) FA & S/S of infection. (b)(6)-2
17AUG03 0800 98.10-99% 78-14-111/63	VSS, 750 cc medium yellow urine, lung sounds clear, Bowel sounds Active x4, Heplock in (L) FA patent And without sign of infiltration. Brisk cap refill, good strength and movement. Pt denies pain. SPC (b)(6)-2
17AUG03 1155	Pt IV infiltrated. New Heplock placed in (L) Hand. SPC (b)(6)-2

(Continue on reverse side)

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IRAQI (b)(6)-4

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(M) AUG DATE	
1335	Pt refused Ensure @ 1000 hrs. SPC (b)(6)-2
17AUG03 1335	I concur c̄ above assessment (b)(6)-2
17AUG03 1530	Pt ASSESSment complete. VS - BP 100/60, HR-97, O_2 SATS - 99%, T-99°. Lungs CTA bilaterally, HR-RRR, BS x 4 quads, Good NEURO ✓'s + cap refill, Drsgs on RUE, RLE, LLE - CDI (b)(6)-2
17AUG03 2230	T 98.3 @ BP 111/64 P 88 R 16 SaO_2 99% Pt AOx3, informed about NPO status p MN pt ate chips and drank water. HRRRS murmur S_1S_2 Lungs CTA (R) Pt has ∅ complaints on assessment BS Active x4 Neuro Vasc ✓ WNL on all extremities (b)(6)-2
18AUG03 0900 100%-87HR 98.2 oral 14 112/55	Pt to go to Surgery this A.M., NPO, VSS, AM Care complete, assessment done, lung sounds clear, S_1S_2, Bowel sounds x 4, brisk cap refill, Drsg Δ's as ordered - wounds are approximating. SPC (b)(6)-2
18AUG03 1300	Pt recovered from surgery. Drsg Δ's to LLE and (R) Foot only. Dr (b)(6)-2 to change skin graft site and donor site in 3 days. Pt given MSO4 for pain as ordered, developed raised, irregular mounds on (L) FA, No SOB. Pt given Benadryl as ordered, raised patches dissolved. SPC (b)(6)-2
18 AUG 1525 98.8 oral 105/58 97HR 14 Resp. 98% RA	Pt complaining of pain at IV site when flushed. New Heploc placed in (L) FA per SG Carbee. No evidence of infiltration at site, however new line was put in. SPC (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	
	OAMC Op Note
2003	Pre/postop DX: (R) hand (dorsum) and (R) Achilles tendon open wound
18 Aug	(skin avulsion)
	Op: skin graft (R) hand (dorsum) and (R) achilles tendon c̄
	(R) ant. thigh donor site
	Surg (b)(6)-2 / (b)(6)-2 / (b)(6)-2 / (b)(6)-2 CRNA (b)(6)-2
	EBL min Fluids 700cc UOP Φ mm 1g Ancef IVPB
	Findings: good grafts obtained, site cleaned, stapled, vaseline gauze/wrap
	bolster sutured, kerlix wrap. Good results. Photos x 12)
	Extubated c̄ difficulty - ↑ PAW (1 cm) c̄ SV, USWN
	(b)(6)-2
	(b)(6)-2 GCDR MD
18 Aug 03 2240	VS: T 97.9 BP 103/32 R16 P80 SaO_2 98% RA Pt AOX3 Lungs CTA (B) Cardiac RRR c̄ murmur S1S2 pt has ↓ c/o pain @ graft site on hand & at graft donor site on thigh. BS Active X4 Neurovasc ✓ WNL on all extremities pt resting comfortably in bed — (b)(6)-2 RN
19 Aug 03 0830	T=98.7, P=85, R=16, BP=112/57, Sat=99% on RA - pt awaken for VS assessment. ✓ A+OX3. cardiac - RRR c̄ MRS, lungs - CTA, abd - BS active X4, skin warm + dry - extremities c̄ good cap refill + pulses B/L. Dressings! - (R) hand, CDI, (R) thigh - mod amt serous drainage, (R) ankle - CDI. Ex Fix remains in place (R) LE, pt denies pain.
	(Continue on reverse side)

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IRAQI (b)(6)-4

PROGRESS NOTES
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DATE	
19 Aug 6	0830 cont. - (L) ankle - Ø S/S of infection or infiltration. (b)(6)-2
19 Aug 1430	Temp-99.2, Resp-12, HR 94, BP 112/59, 97% RA. (L) Foot had very dry skin, lotion applied in order to discourage pt from picking. Assessment complete. Moderate amount of serous drainage on (R) thigh DRSG, (R) Hand (R) leg LS ~~and~~ (L) LS DRSG's all clean, dry, and intact. All pulses normal, brisk cap refill, lung sounds clear, S1 + S2 heart sounds, bowel sounds active x4. (R) leg external fixator in place. Ø pain, Ø complaints, pt OOB to chair. Stool x1 and 500cc medium yellow urine. SPC (b)(6)-2
19 Aug 03 1900	Recieved pt Ø Complaints VSS = HR 70 BP 114/64 ORAL temp 97.5° RR 16 CTAX5, BSAX4 Quads, Voiding yellow urine, Ø pain, Nausea Will continue to monitor (b)(6)-2
20 Aug 0820	T=98.3, P=83, R=16, BP=114/67, Sat=98%. Pt A+OX3 HL (L) ankle area S S/S of infection. Dressing (R) hand = CDI, (R) thigh - mod serous drainage - reinforced c Kerlex, (R) ankle - CDI. Ex fix still intact RLE. Cardiac - RRR S1 S2, lungs CTA, ABD - BS x4. Pt denies pain, want for breakfast on desire foam care at this time. (b)(6)-2
20 Aug 03 1530	T. 99.2 P. 89 R-20 B/P 119/68 SPO2 99%. Pt admitted from FICU. Assessment completed. PERRLA, A+O x3, Breath sounds CTA (B) Apex to base Edema noted on (R) foot, ~~2+~~ Peripheral pulses present x4. Bowel sounds normal active x4. Dressing to (R) hand, thigh, and ankle CDI. Pt up to chair. Ø C/O pain discomfort, S/S of distress (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	
2230 Aug 20,03	A/O x3 - PERRL - LS CTA BS ⊕4Q MAE (R) Hand dressing C-D-I (L) FA IV Hydro' ORIF (R) LE SR 2 80's T 98³ P80 R16 B/P 115-63. PT Has MP at the bedside. Has ∅ % discomfort at this time. per translator will con't to monitor per orders (b)(6)-2
0200 Aug 21, 03	Doing well has No % at this time. say's doing ok per the translator. Will con't to monitor. (b)(6)-2
0430 Aug 21, 03	Resting well NAD will con't to monitor (b)(6)-2

(Continue on reverse side)

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

1RAQ1 (b)(6)-4

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WARD NO.

PROGRESS NOTES

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PROGRESS NOTES

DATE	
22 Aug 2003	0605: (Nursing Notes Continued from reverse) (R) pedal pulse strong. (D) anterior foot suture line ~~S~~ redness, edema, or pain. Pt makes ∅ c/o pain or discomfort. Will continue to monitor. — (b)(6)-2 [redacted] LPN
22 Aug 2003	0130: Pt output per urinal 400cc ~~s~~ difficulties. Will continue to monitor. — (b)(6)-2 [redacted] LPN
22 Aug 2003	0950: Nursing Notes: Pt defecated in BSC, had large amt of liquid stool, denies abd pain. Will continue to monitor. (b)(6)-2 [redacted]
22 Aug 03	1400 - denies c/o pain, ∅SOB, dressing to (R) lower ext. CDI to pin site ~~&~~ thigh; dressing to (R) hand CDI, IV to (R) AC CDI ~~S~~ redness, pain, or swelling will cont to monitor pt — (b)(6)-2 [redacted]
2230 22 Aug 03	Took over care. VSS T 98.3 P 72 R 18 BP 113/59 Sat's 94% RA A/O x 3 PERRL Chest CTA HEART RRR Abd (+) BS x4 non-distended non-tenderness MAE (R) Hand S/Growth. C-D-I (R) LE ORIF + S/Graft C-D-I. Will cont to monitor per orders. Has ∅% discomfort at this time. (b)(6)-2 [redacted]
Aug 23, 03 0120	Sleeping eyes closed nares and flail of chest noted will cont to monitor per order. (b)(6)-2 [redacted]
0900	T 98.2F, BP 117/66, HR 80, RR 14, SpO2 100% on RA, NAD VSS, Dx + LE CDI, lung sounds clear, bowel sounds active x4 quad., pt sitting up in bed — (b)(6)-2 [redacted] RN

MEDICAL RECORD	PROGRESS NOTES
DATE 21 Aug 03 1015	Pt assessment complete. Pt VS - 116/63, 80 Bpm, 100% SpO2, 97°, RR 15. Lung fields CTA. Ø cough. + Rales x4, good cap. refill. Pt able to move all extremities. Dressings changed by Dr's. Ø signs of infection. Dressings CDI. Bowel sounds + x4. Pt up to chair. Pt states thru interpreter "I feel fine." Will continue to monitor. (b)(6)-2
21 Aug 03 1400	pt resting c̄ guard @ bedside, shows no s/s of difficulty breathing, denies c/o pain through hand motions, dressing to (R) leg (pin site: thigh) CDI, dressing to (R) hand CDI, IV site shows no s/s of redness, swelling or pain (b)(6)-2
2200 Aug 21, 03	Resting well NAD VSS T 99° P 94 R 18 B/P 112/63. A/O x3 PERRL SR BS CTA MAE will cont to monitor pt per the orders (b)(6)-2
22 Aug 03	0605: ~~Assumed~~ ERROR (b)(6) Nursing Notes: Assumed pt care. VSS: BP 116/70, P83, T 98.5, RR 16, Pulse Ox 99% on Room Air. IV HL in (R) FA patent & flushes easily, site ∃ redness, edema, or pain. (R) hand dressing CDI. NSR, Ø ectopy, Ø murmurs, PPP (B) lungs CTA, cap refill (F) 1 sec. BS (D) hyperactive x4 quads. (R) upper leg drsg CDI. (R) Ext Fix to (D) lower leg c̄ drsg @ pin site proximal ankle. (b)(6)-2

(Continue on reverse side)

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

Iraqi (b)(6)-4

REGISTER (b)(6)-2

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509-111

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 Aug 03 1430	V/S: T-99.1 P-91 R-20 B/P 111/59 SPO2-100% RA Assessment completed. Lungs CTA A/B (B). Bowel sounds active x4 Peripheral pulses strong x4. A&O x3. PERRLA, Dressings CDI, ⊘ S/S of infection
28/8/03	Pt the stump (R) calf (R) Dorsum of hand ≈ 95% + pink ⊘ Drainage from (R) Thumb (P) (1) If wounds healing well, Transfer to GPW Camp 8/29/03 (Friday) (2) WBAT CUE (3) pt instructed ⊘ SGT Hansen for ambulation ⊘ crutches (4) Daily Dressing Changes continue wounds c/b (5) NWB (R) LEX 2 weeks

(b)(6)-2

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

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

(b)(6)-4

WARD NO.

Iraqi (b)(6)-4

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FIRMR (41 CFR) 201-45.505
509-111

PROGRESS NOTES

DATE	
23AUG03 2210	VS – T-98.5 HR 91 Sat 99% BP 118/64 RR 12 Pt appears to be sleeping in bed, NAD. Drsg to (R) UE + RLE CDI. NO c/o pain. Will continue to monitor — (b)(6)-2
24Aug03 1040	VS – BP 112/62, HR 81, RR 12, SpO2 100% on RA, T 98.4 IV in (R) fa was DC'd; lungs sounds clear, BS active x4 quad.; Dr (b)(6)-2 did dressing Δ's to (R) hand + RLE; CDI; pt. given Levaquin PO; NAD, VSS pt. sitting up eating will cont to monitor — (b)(6)-2
25AUG030530	Pt slept well through night. Voiced no c/o pain/discomfort. Voided QS clear yellow urine/urinal. — (b)(6)-2
25Aug03	1000 – Pt resting quietly in bed; ∅ c/o pain or discomfort. VSS T98.2, P83, RR 16, Pulse Ox 100%, BP 118/69. Pt breathing even and unlabored. Will continue to monitor. — (b)(6)-2
25Aug03	1200 – Pt has 350 cc output of dark, yellow urine per urinal. Pt refused breakfast & lunch. Will continue to monitor. (b)(6)-2
25Aug03	1330 – Pt requested equipment in order to bed bathe self. Gave pt the equipment & pt executed a self bed bath ∃ difficulty or assistance. (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

AL RECORD — PROGRESS NOTES

TE	NOTES
03	1400 pt resting comfortably, Ø c/o pain Ø S/S of SOB will continue to monitor pt (b)(6)-2
25 Aug 03	Ø c/o pain, discomfort. Ø S/S of distress. BMX1,
2115	urinating s difficulty OOB for 1°. Ate oven food. Stood on crutches x 10 minutes. Personal hygiene completed. Resting comfortably. (b)(6)-2
Aug 25, 03 2200	Have cont in bed resting looking at a book. VSS T 98.3 P 78 R 12 BP 115/64 S.A's 99% RA. PERRL A/O x3 Chest CTA Heart RRR Abd Soft-Nontender MAE Hand dressing to (R) Hand. Intact & good sensation. OLIF to (R) LE. Dressing to upper (R) leg intact. Ø c/o discomfort at this time. Will cont to monitor. per the orders (b)(6)-2 (b)(6)-2
Aug 26, 03 0200	Resting w/ eyes closed. NAD will cont to monitor per orders. (b)(6)-2 (b)(6)-2
Aug 26, 03 0530	NO D's in states (b)(6)-2 (b)(6)-2
26 Aug Ø3 0800	Pt appears to be resting comfortably. No distress noted. (b)(6)-2
26 Aug Ø3 0900	Drs (b)(6)-2 in, Dsgs Ad-to (R) achilles graft site & (R) thorax graft site. All remaining staples removed, DSD reapplied by Dr (b)(6)-2 sites clear, & purulent drainage. (b)(6)-2
26 Aug 03 1400	Sitting T in bed. Voices Ø c/o. Ø apparent distress. Continue to monitor (b)(6)-2 Cpt AN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | NUMBER

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. (b)(6)-2

Iraqi (b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE	NOTES
Aug 26, 03 2215	Sleeping eyes closed. NAD guard at the bedside. Rises and fall of chest noted. Will cont to monitor per the orders. (b)(6)-2
Aug 27, 03 0110	Resting in bed NAD (b)(6)-2
Aug 27, 03 0530	Resting well settling up in bed. NAD Ø c/o at this time. (b)(6)-2
27 Aug 1000	BP 117/62 HR 89 RR 18 SpO2 100% RA T 96.9. Pt drank & ate. Resting quietly in bed. (b)(6)-2
27 Aug 1500	↑ to amb + use BSC x3. Some loose stools. Walking on crutches ⅗ diff. Voices Ø c/o. Ø apparent distress (b)(6)-2
28 Aug 03 2205	Pt up ambulated c̄ crutches. (+) BM - loose stool. Ø difficulties c̄ urination. Awake talking c̄ ml. Will continue to monitor for A. (b)(6)-2 (0035) c/o pain in leg p̄ ambulation. Medicated c̄ tylox. (b)(6)-2
28 Aug 1050	BP 119/65 HR 89 SaO2 100% T 96.5. Pt resting this morning ⅗ comfort. (b)(6)-2
8/28/03	wounds O/D/I Skin graft c̄ 98% take Ø Drainage walking c̄ crutches, bearing weight on (L) LE & PWB (R) LE Gastrocs short distance Plan (R) Thumb MCPJ fusion c̄ ICBG in 2-3 months p̄ wounds healed / (R) LE fx healed / & evidence infection

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
3 August 03 @ 2330	Pt sitting up in bed picking scars. AAO. Pleasant disposition. Ambulate on crutches c̄ SGT (b)(6)-2 Ø complaints @ this time. Will continue to monitor and prepare for d/c. (b)(6)-2
29 August 03 06:15	Nursing Notes: Assumed pt care. VSS: T 97.1, BP 116/64, P/78, Pulse Ox 99% on room air, RR 17. Pt resting quietly in bed c̄ eyes opened. Lung CTA, Ø resp distress noted. NSR, Ø ectopy, Ø murmurs. Ø IV access, ppp, MAE. Pt refused breakfast tray. Ø c/o pain. Will continue to monitor pt. (b)(6)-2 LPN
29 August 03 10:21	Nursing Notes- Pt DC'd to EPW Camp via HMMV accompanied by 3 MP's c̄ his personal belongings, medicine and crutches. Pt ambulated c̄ crutches c̄ difficulty & slow, steady gait. (b)(6)-2 LPN

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.

Iraq (b)(6)-4

PROGRESS NOTES
Medical Record

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

558-103 (See Instructions on Back of this) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
26	Jul	03	1800

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☑ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): UNKNOWN

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	1800		
BP	104/50		
PULSE	110		
RESP.	24		
TEMP.	99.6		
WT. (Child)	99%		

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

ORDERS	INITS.	TIME
R Femur PA+LAT	[redacted]	
(R) Tib/Fib	[redacted]	
I-stat 6 cr CBC	[redacted]	1800
Bolus T Lactate N/S	[redacted]	1800
(R) hand Xray	[redacted]	
2mg Morphine	[redacted]	1802

ASSESSMENT/DIAGNOSIS: MULTIPLE PENETRATING WOUNDS, EXTREMITIES

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

TIME SEEN BY PROVIDER: on arrival

22y Iraqi ♂ brought to CSH in custody of military police from local hospital. Individual sustained GSW and fragmentation wounds to (R) and (L) shoulders, (R) hand and B/L lower extremities and feet. Operated (?) debrided at local facility, details of care not available.

PmHx: Ø Meds: unknown Habits: unknown

PSxHx: Ø Allergies: NKDA

GENERAL: Thin Iraqi ♂ alert/answers questions through interprete

6.9 | 8.7 / 26.7 | 152

INTEG: warm + dry Ø rashes - wounds as noted

137 | 106 | 1.0 / 3.0 | 9.1 | 10

HEENT: Frag wounds + abrasions (L) chin sutured scalp laceration (R) parietal area

LUNGS: CTAB3 w/RR- chest rise symmetric

CV: HRR, tachycardic, ↓ S1/S2

ABDO: Soft/NT/ND/Ø mass abrasions (R) LQ

~~[illegible]~~

CHEST: Healing penetrating wounds (L) and (R) shoulders

BACK: Healing grazing wounds upper back no penetrating trauma

GU: Ø penetrating trauma

BUTTOCKS: Ø trauma

EXTREM: Penetrating wounds LE's feet BL (R) hand c̄ partial amputation (R) thumb

(CONTINUE ON SF 507, IF NEEDED)

DISPOSITION (Check all that apply)
- ☐ HOME ☐ FULL DUTY

QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.

MODIFIED DUTY UNTIL: DAY | MONTH | YEAR

REFERRED TO (Indicate clinic): ORTHOPEDICS

- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

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

(b)(6)-4

SIGNATURE OF PROVIDER AND TITLE: (b)(6)-2 (b)(6)-2 LTC, MC

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

Transport x-rays show (L) Tib-Fib fracture

Case transitioned to orthopedic surgery at 1830

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82) Prescribed by GSA and ICMP

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	26 JUL 03
DOS	26 JUL 03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2	

Safety Checks	D	E	N
BVM at bedside			(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			(b)(6)-2
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MDA	ICU	26 JUL 03

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

I raq (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER(*Specify*)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R																			brachial				2	
	RADIAL L																							3	
	DORSALIS PEDIS R																		Unable to assess					X	
	DORSALIS PEDIS L																							Y	
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale																								4	
																								8	
EDEMA																								Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)																								✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)																								5	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																							✓	
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT																								
	SUPINE																							✓	
	HOB 30 DEGREES																							✓	
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE																								
	PAIN SCALE (1-10)																							8	
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended																								2	
BOWEL SOUNDS (active all quads)																								✓	
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds																						(b)(6)-2		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV	(L) FA 18g	26 JUL	Ø S/S of infection in fi

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment –

DATE:

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open																								4	
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response																								5	
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response																								6	
GLASCOW COMA SCALE (A+B+C)																								15	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R																							2	
	L																							2	
MOVEMENT (See Motor Function Scale at Top of Page)	RUE																							4	
	LUE																							4	
	RLE																							4	
	LLE																							4	
GRIP (S) Strong (W) Weak (-) absent	R																							3	
	L																							4	
RESPIRATIONS	REGULAR																							✓	
	IRREGULAR																								
	UNLABORED																							✓	
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL																							5	
	LUL																							5	
	RLL																							5	
	LLL																							5	
	BOTH BASES																							5	
COUGH	NONE																							✓	
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)																							2	
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS																									

(b)(6)-2

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26 JUL		2325	From Recovery - Refer to PACU flow sheet nursing care problems section for multiple lacerations, surgical wounds, dressings. PT received a total of 20 mg MSO4 in recovery as well as Tylox #1 PO @ 2315. PT now resting quietly, cont. on 2 l NC - will cont to clean O2 OTR as PT tolerates. (b)(6)-2 MOCM

	INTAKE								Total	OUTPUT					Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100																
1200																
1300																
1400																
1500																
1600																
8 HR									16 HR.						16 HR.	
1700																
1800																
1900																
2000																
2100																
2200																
2300	1300 OR									(b)(6)-2 100						
2400																
8 HR									24 HR.						24 HR	

CRITICAL CARE FLOW SHEET

(b)(6)-2

LOS DATA	
DOA	26Jul03
DOS	26Jul03
POD	

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	
24 Hour Output	
Weight on Admission	
Weight Yesterday	
Weight Today	

NURSE'S SIGNATURE	Initials
(b)(6)-2 (b)(6)-2	(b)(6)-2
LT, An	
LT/M	

Safety Checks	D	E	N
BVM at bedside	(b)(6)-2		
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach			
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 S/C LVN	ICU #1	26Jul03

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

Iraqi (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOWCHART
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700

MEDCOM - 1411

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PULSES (4) Bounding (3) Full (2) Normal (1) Faint (0) Absent	RADIAL R		*					UTA							UTA								UTA		
	RADIAL L		2					2							2								2		
	DORSALIS PEDIS R		*					UTA							UTA								UTA		
	DORSALIS PEDIS L		*					UTA							UTA								UTA		
SKIN (1) Dry (2) Clammy (3) Warm (4) Cool (5) Flushed (6) Cyanotic (7) Jaundiced (8) Color Normal (9) Pale			1 3 8					1 3 8							1 3 8								1 3 8		
EDEMA			*												fl										
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓					✓							✓								S1S2		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			✓					✓							SR								✓		
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST														✓										
	BSC																								
	DANGLE																								
	CHAIR																								
POSITIONED	RIGHT																								
	LEFT		S2					S2															S2		
	SUPINE		✓					✓							✓								✓		
	HOB 30 DEGREES							✓							✓										
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE		✓					✓							✓										
	PAIN SCALE (1-10)																						*		
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN (2) Soft & Flat (1) Distended			2					2							2								2		
BOWEL SOUNDS (active all quads)			+					✓															✓		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.																									
SKIN INTEGRITY	No Breakdown		✓					✓							✓								✓		
	Surgical Wounds														✓								✓		
	Rashes, Lac's, etc																						✓		
DRESSING (Dry & Intact: specify site below)															✓										
#1 (R) shoulder			✓					✓							✓								✓		
#2 (R) Forearm/Hand			✓					✓							✓								✓		
#3 (L) Calf/Foot			✓					✓							✓								✓		
#4 (R) Calf/Foot			*					✓							✓								*		

(b)(6)-2

(b)(6)-2

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	(R) Forearm	??? 26 July (?)	3 s/sx infx or infiltration
PIV 18G	LFA	? 26 July 03	PATENT 3 s/sx of infection or infiltration
PIV 18G	(L) FA	26 July 03	patent; Ø s/sx of infection or infiltration
PIV 18G	(L) Forearm	? 26 July 03 ?	patent 3 s/sx of infx or infiltration

PUPIL SIZE	PUPILS	
1 mm	=	Equal
2 mm	R	Reactive
3 mm	NR	NonReactive
4 mm	L > R	Left Larger
5 mm	R > L	Right Larger

MOTOR FUNCTION

0 = No Movement
1 = Slight Flicker/ Trace of Contraction
2 = Active (Gravity Eliminated)
3 = Active: against gravity, but not against resistance
4 = Active: Against Gravity and Resistance, not full strength
5 = Full Strength against Examiners Resistance

CHART CODES

Present ✓
Not Applicable /Absent (blank)
Refer to Nsg. Notes X
No Change from Previous Assessment --

DATE: 27 Jul 03

TIME		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
A. BEST EYE-OPENING RESPONSE (4) Opens Spontaneously (2) To Pain (3) To Voice (1) Does Not Open			4					4							4								4		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response			through intubation 5					5							UTA								N/A		
C. BEST MOTOR RESPONSE (6) Obeys Commands (3) Flexion to Pain (5) Localizes to Pain (2) Extension to Pain (4) Withdraw to Pain (1) No Response			6					6							6								6		
GLASGOW COMA SCALE (A+B+C)			15					15							15								15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2+																				2+		
	L		2+																				2+		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4					4							4								4		
	LUE		5					5							5								5		
	RLE		3					3							4								4		
	LLE		4					4							4								4		
GRIP (S) Strong (W) Weak (-) absent	R		*					UTA							UTA								UTA		
	L		S					S							S								S		
RESPIRATIONS	REGULAR		✓					✓							✓								✓		
	IRREGULAR																								
	UNLABORED		✓					✓							✓								✓		
	LABORED																								
	SHALLOW																								
	RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished	RUL		5					5							5								5		
	LUL		5					5							5								5		
	RLL		5					5							5								5		
	LLL		5					5							5								5		
	BOTH BASES																								
COUGH	NONE		✓					✓							✓								✓		
	SPONTANEOUS																								
	PRODUCTIVE																								
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																									
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FIO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)		1L					1L							1L								1L		
	FM (l/min)																								
ETT #_____	NRBM (l/min)																								
	ETT _____cm gums																								
ETT CARE / POSITION CHANGE																									
ETT / NT SUCTIONED																									
INCENTIVE SPIROMETRY DONE																									
COUGH / DEEP BREATH																									
INITIALS			(b)(6)-2																						

(b)(6)-2

1

VITAL SIGNS

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
0100		95	13	119/61	97%												
0200		~~95~~	~~13~~	~~119/61~~	~~96%~~	(b)(6)-2											
		85	12	108/47	96%												
0300		92	10	113/57	96%												
0400		86	8	99/49	96%												
		~~81~~	~~9~~	~~103/46~~	~~96%~~	(b)(6)-2											
0500		81	9	103/46	96%												
0600		89	9	104/45	98%												
0700	97.4	89	11	102/48	98%	IL/NC											
0800		68	12	105/43	96%	IL/NC											
0900		99	17	96/49	91%	IL/NC											
1000		77	12	113/53	98%	IL/NC											
1100		82	12	111/52	98	IL/NC											
1200		83	15	108/50	97%	IL/NC											
1300		87	16	111/54	100%	"											
1400	99.2	93	19	113/54	98%	"											
1500		87	13	107/49	96%	IL/NC											
1600		89	12	104/46	97%	IL/NC											
1700		106	13	115/57	97%	on IL/NC											
1800		92	15	118/48	96%	on IL/NC											
1900		86	18	118/53	98%	on IL/NC											
2000	99.6	89	19	118/56	100%	on IL/NC											
2100		89	22	104/49	96%	on IL/NC											
2200		82	13	109/54	100%	on IL/NC											
2300	99.7	94	10	124/62	96%	on IL/NC											
2400																	

	INTAKE									OUTPUT						
	IV	IVPB	PO						Total	Urine	Stool				Total	COMMENTS
0100	100 / 100															
0200	100 / 200															
0300	100 / 300															
0400	100 / 400															
0500	100 / 500															
0600	100 / 600															
0700	100 / 700															
0800	700	150 / 150														
8 HR	700	150							8 HR. 850						8 HR. 0	
0900	100 / 100															
1000	100 / 200															
1100	100 / 300									300 / 300						
1200	100 / 400															
1300	100 / 500		200 / 200													
1400	100 / 600															
1500	100 / 700	150 / 150														
1600	100 / 800															
8 HR	800	150	200						16 HR. 1150						16 HR. 300	
1700	100 / 100									900 / 900						
1800	100 / 200															
1900	100 / 300															
2000	100 / 400															
2100	100 / 500															
2200	100 / 600									625 / 1525						
2300	100 / 700															
2400																
8 HR									24 HR.						24 HR	

NSN 7540-00-634-4123

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
27Jul03	0230		Pt assessment complete. Pt is A+O x 3 (assessed through interpreter) PERRLA (L) grip is strong (R) grip unable to assess due to fx and bandage. pt is able to move all fingers on (R) hand. Cap refill on (R) hand and (R) feet <2 sec. 2+ pulse on (L) radial artery. Pt is able to wiggle all toes (R) and all fingers on (R) hand. Fingers on (R) hand is slightly edematous and toes are also slightly edematous. All dressing except (R) Calf/foot are CDI. (R) Calf/foot dressing has small amount (3inch diameter) of serosanguenous drainage. Drainage has been circled on dressing c̄ date and time. Pt has yet to urinate this shift. Will continue to monitor. ——— SPC [(b)(6)-2]
27 JUL	0935		Auscultation done – cardiac – RRR – murmurs lungs CTA, abd – (+) BS all quads. [(b)(6)-2]
27Jul	0700		A&O x 3. VSS. (+) Pain. Refused breakfast. No Δ from previous assessment. ——— [(b)(6)-2] LCT, RN
27JuL03	0945		Pt has not voided. TRANSLATOR STATES Pt said he does not have to urinate and he is not having pain. Pt states he would let us know if he does [(b)(6)-2] LCT, RN
27Jul03		1030	Voided DARK amber urine 300cc [(b)(6)-2] LCT, RN
27JuL03		1330	ATE CAKE & drank one juice. Refused the rest of lunch meal. Medicated c̄ TYLOX II p [(b)(6)-2] LCT, RN
27 Jul 03		1445	Pt. resting in bed; HOB ↑@ 30°; able to communicate through sign language; answers yes/no; responds appropriately. Ancef given as ordered. No other concerns @ this time. Ext. fixator in place in RLE; LLE covered c̄ ace bandage. (+) CMS; toes dk. edematous @ +1; (R) shoulder c̄ bulky dsg. open wound to (R) lat. shoulder; CDI; (R) hand also covered c̄ bandage; (+) CMS. Will continue to assess and monitor. ——— [(b)(6)-2] LCT/RN
		2007	Pt c/o "ouchy", pointing to (R) knee; given 50mg of MSO4 IVP as ordered. Will continue to reassess and monitor. ——— [(b)(6)-2] LCT/RN