AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Oct 03	1640 Surgery
	Pt c̄ Temp 101.2 Repeat WBC = 14.2 (↑)
	Exam: Abd: Tender, Guarding, ± Rebound
	Bowel Sounds Hypo-Active.
	Pt's clinical condition is worse c̄ Temp, ↑WBC,
	Abd Tenderness.
	Plan Exp Lap. (b)(6)-2
	Pt remains slightly somnolent and refuses to converse with us thru interpreter. I feel clinically the surgery is indicated as pt appears uncomfortable from abd pain, has ↑HR, ↑ Temp, increasing WBC. (b)(6)-2
19 Oct 03	Surgery
1650	I agree with above assessment. I agree pt should undergo emergent laparotomy to R/o intraabdominal injury. Has ↑'d WBC, tachycardia and Temp of 101.2. Stable

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | (b)(6)-2 | SPONSOR'S ID NUMBER (Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGIS (b)(6)-2 D 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)

DATE	NOTES
19 Oct 03	2100 Op Note
	Pre-op Dx: Shrapnel Wounds to Abdomen
	Post-op Dx: Shrapnel Wounds to Abd c̄ Sm Bowel + Colonic Injury
	Proc: Exp Lap, Repair of Sigmoid Colon Enterotomy, Repair of Small Bowel Enterotomy Resection of Small Bowel Injury with Stapled Anastamosis. Appendectomy
	Surgeon: (b)(6)-2
	Anesth: GETA EBL = 200 Fluids: 5000
	Findings:
	Small 3-4mm Sigmoid Colon Injury, Opened Slightly + Minimally Debrided. Closed in Two Layers c̄ Interrupted 3-0 Silk
	1cm Prox Sm Bowel Injury - Repaired in Two Layers with Interrupted 3-0 Silk
	3cm Prox Sm Bowel Injury. Resected + Repaired c̄ Stapled Side to Side (Functional End to End) Anastamosis.
	Incidental Appendectomy Performed
	(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

GYN Staff Note

20OCT03 0912

S: pt seen problems discussed through Fil Interpreter
Pt having pain in abdomen "can't talk" would like something for pain. long MS since surgery. S/P 1U PRBC transfusion. No other c/o's.

O: VSS Tmax 99.6° since surgery
lungs CTA b/c SWR
heart RRR i (m) clicks/rub
abd soft + NTND i masses neg; Bandage dry (+) tender
ext PPP = c/ strong p.e/c/c

OBS all 4 quad
OSW

LAB: | 10/130 .9 Bili 2.5 AST 81 ALT 74 12.2 12.9 37.4 234

Imp: (1) S/P Partial SBR reanast; large + small bowel enterotomy repairs, appy POD # 1

PLAN: (1) consider tube feedings
(2) continue abx, IV fluids
(3) recval pm

(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)

POTUS (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

DATE	NOTES
20 Oct 03	Nutrition Consult
S	Consult for nutrition support recs.
O	Iraqi ♂ s/p partial SBR, reanastomosis, large + small bowel enterotomy repairs. POD #1
	Diet: NPO ⊖ bowel sounds Meds: Urasyn, zantac
	Labs (10/20) gluc 130, Bun/Cr 10/.9, alb 2.5, chol < 20
	Height/weight: N/A weight est @ 135# height ~65"
A	Nutr dx statement
	(1) Possible malnutrition based on lab/anthropometric data. ↓alb could be 2° hydration/fluid shifts + is not a reliable indicator of nutr status in critically ill.
	(2) ↑ needs to support healing
	Nutr needs est c 1800-2100 Kcal/d (30-35 kcal/kg) + 75-90 gm pro/d (1.2-1.5 gm/kg.)
P/P	Enteral feeding c̄ return of bowel fxn to improve nutr status + promote healing.
	Osmolite HN - initiate at 20 cc/hr & advance q 6-8 hr as tolerated to goal rate of 80 cc/hr to provide 85 gm pro and ~2000 Kcal, 1600 cc free water. Will need additional 400 ml H_2O to meet fluid needs. Monitor Mg, K, PO_4 for refeeding syndrome. Will follow.
	[redacted] [b)(6)-2] NLAT, SP, MD, RD

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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REGISTER NO. | WARD NO.

POTUS [b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
POTUS # (b)(6)-4			

DATE	NOTES
	GYN/Surg Note
210703 1000	SPT seen problems discussed through interpreter. Pt pain better and minimal pain med requested. Patient has some "dysuria, difficulty urinating" but has catheter in. Mobilizing more fluid c̄ diuresis HCT, ↓ in abd pain overall. ⊖ flatus @ BM. (R) knee sore near knee cap
	O: VSS TMax 100.9° I ≈ 0, ~100cc NG output
	lungs CTABC s̄ wh
	heart RRS w/o clicks/rubs
	abd soft NTND ; wound neg. (+) BS (hyp) in 3 quad, minimal serous drainage on bandage, dressing Δ'd last pm. Incs PPP & strong & equal ; (R) knee palpated ⊖ edema crepitence or swelling ⊖ Homans ⊖ Mose
	LAB: 120 | 99 | 10 (133 6.2) 9.1 / 26.6 (195 4.0 | 27 | 1.8
	IMP: (1) S/P ex lap, small + large bowel enterotomy repairs, partial SB resection c̄ 1° peanastomosis, appy POD #2
	PLAN: (1) monitor I+O orally → consider pulling NG tube if output low
	(2) tube feed/oral intake when bowel fnx
	(3) ice chips, ambulation
	(4) seen c̄ Dr. (b)(6)-2

(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

21 Oct 03 2100

Temp 101.8, Pt in now distress
- Wound Open & Clean
- Chest → ↓BS (R) Base

CXR → Atelectasis (R) Base
NG in Duodenum
Had Pt do Incentive Spirometry.
Also did N-T Stimulation c̄ Moderate Effort Cough.
(A) Temp most likely dc to atelectasis
(P) Continue IS & Coughing.

(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.

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

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MEDICAL RECORD	PROGRESS NOTES

DATE	POD #3 NOTES
22OCT03 0950	S: pt seen problems discussed. Interpreter not available. "Water hurts" and pt is ambulating, so Foley could be pulled. Not coughing/expectorating effectively due to pain. Abd pain better. No N/V, but sipping water causes his stomach to "hurt"
	O: VS Tmax 101.8 ax
	Lungs ↓ BS in (R) lower field, otherwise CTA. HCC sinus heart RRS tachy x̄ tachy
	abd bandage dry, +BS, NTND s marked neg
	ext PPP - 1 strong pedal
	Imp: (1) S/P appy, ex lap, enterotomy repair (SB + LB), part SB resection & 1° anast - POD #3 (stable)
	(2) FUO - suspect atelectasis/bronch vs UTI
	PLAN: (1) remove Foley today
	(2) await better BS before clamp NG tube + consider D/C or tube feeding.
	(3) replace Na+

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

509-114

DATE	NOTES
	GYN note
22OCT03	S: pt seen problems discussed through interpreter.
2000	Called to eval pt, re: 102° temp elevation. Rectal tylenol given. Pt reports 2 voids since Foley removed → no dysuria or difficulty. (+) better cough effort → still not forceful. Ambulating ī difficulty (-) Flatus (-) BM, (+) belching. Tolerating sips of H2O ī N/V. Abdominal pain low baseline well controlled
	O: VSS Tmax 102.5° (on Primaxin)
	lungs CTA b/l ī wh (+) rochi (L) base clear c̄ cough
	heart RRR ī murmurs
	abd: incisional – no redness/calor, ø ecchymosis or erythema, NTND ī masses neg (+) BS all 4 quad (-) rebound
	ext PMP = ī strong ø c/c
	LAB: u/A sm. bacteria (-) nit (-) LE sm blood
	IMP: (1) S/P enterotomy repairs (SB+LB), partial SBR ī 1° reanastamosis, ex lap + appy POD#3
	(2) FUO suspect atelectasis vs bronchitis/pneumonia
	PLAN: (1) Δ'd abx, encourage cough + expectoration + IS
	(2) Foley, NG out
	(3) clear liquids as tolerated
	(4) continue present management
	[redacted] (b)(6)-2
20 Oct 03 2045	
	As Above.
	Lung Exam: Breathsounds Absent @ Base.
	Pt N-T Suctioned, Good Cough + Sputum.
	Re-Exam: Much Better Breathsounds @ Base
	[redacted] (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

23 Oct 03 0936 Surgery POD #4

- Pt ambulating
- Tm 102.4 (Current 100.6)
  Lungs: Decreased (R) Base, But Improved.
  Pt with improved Resp effort & cough.
  Abd: Wound Open, Clean.

23 / 219 < 5.5 136 / 3.6 | 99 / 24 | 12 / 1.0 < 117

- Pt stable overall
  Improved Resp Status but still c̄ Atelectasis vs
  Pneumonia (R) Base
- Cont pulm Rx - Nebs, N-T Suction
  Primaxin

(b)(6)-2

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

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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

ISN 7540-00-634-4176

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
23 Oct 04	(2230) Nurse note: Pt sleeping supine position; easily arousable to gentle touch. Pleasant disposition; cooperative. Denies pain @ this time. D5NS c̄ 20 KCL infusing to 18G PIV to (R) FA. ⊘ S/S of complications. Midline incision dressing c/d/I. Active BS x 4 quadrants. Lung sounds diminished in middle + lower lobes. (+) Spontaneous productive cough. thick / yellow + bloody. return demonstration given for I/S use. Will continue to monitor for Δ in status. — [(b)(6)-2] CPT
24 Oct 04	0130 - OOB to BSC unassisted; movements slow and steady. Ambulated from unit to DFAC. staff and MP escort present. Urine not as concentrated as before. (+) small amount mucusy stool. Pt back to bed and sleeping @ present time. — [(b)(6)-2] CPT
	0400 Vitals - Bp 123/57 - RR - 14 - HR 99 - Temp 100.7 Pox - 99%.
	0730 VS - BP 123/71, HR 102, RR 16, SpO2 96% on RA T 101° pt had med BM; IS used + was able to achieve 3 balls x4; NAD; pt. now resting in bed; does not c/o any pain; has not required any pain med — [(b)(6)-2]
	@ 0930 VSS BP 120/76, HR 101, RR 14 SpO2 99% RA T 101° tylenol given 650 mg PO per doctors orders —

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

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

Potus [(b)(6)-4]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
24oct03 @ 1030	Ø c/o pain at this time will continue to monitor [illegible] pt up to chair, walked 3 times to DEFAC and back. Tolerated well Ø c/o pain Dizziness or lightheaded. Will continue to monitor [illegible] [(b)(6)-2] [illegible]
1230	VS BP 123/70, HR 101, RR 14, SpO2 98% on RA; T 99°; pt ate (drank) 50% of clear liquid diet; Ø c/o pain; tolerated well; IS used + achieved 3 balls x6; NAD. pt. now resting in bed; will cont. to monitor — [(b)(6)-2]
1500	Pt ambulated hall x3 ō difficulties. Able to get self out of bed ō assistance. Used IS when returned from ambulation. Able to maintain suspension on all 3 balls on IS. Dressings ō to fingers on (L) hand bacitracin applied. IVF D5½NS ī 20mEq KCl/L infusing @ 50cc/hr ī 18G in (R) FA. Tolerating P.O. BS Active x4. Pt cooperates ī commands. Lungs clear throughout but diminished in (R) base. Coughs ī productive cough — [(b)(6)-2]
1600	T 99° (O) BP 117/65 P 97 R 18 SaO2 100% pt back in bed. Voided clear yellow urine — [(b)(6)-2]
1705	C/o 2-3/10 abd pain, states pain ↑ to 6-7/10 ρ drinking cold fluids. Percocet ī po given for abd. pain. Had very [illegible] hard stool, gets in/out of bed ō assist. [(b)(6)-2]
1900	T 100.7 (O) BP 119/66 HR 97 SaO2 98% R 18 Pt c/o mild headache [(b)(6)-2] ~~Pt OOBWC~~
2030	Pt ambulated to radiology for PA/lat CXR. Pt c/o feeling dizzy from medication (Percocet). Used IS. Also explained their intake need for pt to ↑ po fluid intake — [(b)(6)-2]
2130	IV in (R) forearm d'd because pt c/o pain. XC ~~mf~~ 206 [illegible] started in (R) upper arm — [(b)(6)-2]

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ANDARD FORM 600

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
240CT03 0900	Surg Note POD #5 Pt seen problems discussed thru interpreter. Pain continues to improve / new c/o's. Pt walking, ambulating c difficulty (+) Flatus (+) BM (x3) since yesterday. Pt doing IS + also breathing txs. Fever persists + resp. effort still ↓ O: VS: Tmax 101° @ 0730 today lungs CTA bilc c WR. ⊕ Rhonchi / ? Rales (R) side >>> heart RRR c ⊕ clicks abd soft NTND c nasal mucosa dry well approx, ⊕ BS all 4 quad lgt PPP = ⊖ strong pedal LAB: 6.3 / 9.3 / 26.9 / 328 — 136 / 98 / 11 / 112 — 4.0 / 22 / 17 Dx: ① S/P ex lap, partial SB resection c reanast, small & large bowel enterotomy repairs, appy POD #5 Plan: ① ↑ diet to clears ② FLO - doubt belly @ this stage ② continue breathing txs, IS ③ encourage ambulation (b)(6)-2

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

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

POTUS (b)(6)-4

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

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

24Oct03 @ 2215 Nurse note: Vitals Bp 125/68, HR 104, Temp 100.0, RR20, Pox 97%. Pt sitting up ⊽ N-T suctioning. ⊕ bloody secretions. min amount. 20G PIV to ® arm. BS clear except to RLL (diminished) BS x4 quadrants. Dressing to midline incision intact c̄ 2 small areas of drainage. Encourage deep cough/breathing. and use of I/S. Will continue to monitor pt. A in stable — [redacted] CPT

@2345 Dressing Ned to midline incision. Incision moist c̄ open areas ⊕ minimum drainage. Staples + sutures inplace to keep incision approximated. 0% of infection. Pt tolerated well. — [redacted] CPT

25Oct03 0200 — Vitals - Bp 118/55, Pulse 85, POX 98%, Temp 99°, RR 20 - Easily arousable. Ø complaints @ this time. I/S used — [redacted]

0630 - VS HR 101, BP 129/67, SpO2 100%, RR 14, T 100.1; lung sounds clear ® in all lobes; BS active x4 quad.; pulses ⊕ + normal ® radial + ® pedal; NAD; VSS; pt denies having any pain; IS was used + pt able to maintain 3 balls for 2-3 sec. each time; pt is resting c̄ eyes closed; stated he would like to wait on breakfast; will cont. to monitor — [redacted] PWMD RC

1030 T 100.3, BP 128/69, HR 107, 98% SpO2 on RA; pt was up out of bed this AM, ambulated up + down corridor x3; pt

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	LAST	FIRST	MI	

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

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
25Oct03	1030 cont. then sat in chair for 1 hr. + did personal hygiene; dressings were Δ'd on (L) hand; IS was used again + was able to maintain 3 balls; had med. BM (liquidy in consistence); now is resting in bed; MD is changing dressing to abdominal incision; NAD; VSS; will cont. to monitor — [redacted]
25 Oct 03 1450	VS: BP 127/63, T-101.2 oral, P-108, RR-40, SpO_2 96% on RA. Awake, alert, appears oriented, (B) grips equal + strong, MAE, PERLA. Heart sounds normal, tachycardic. Lungs CTA in all lobes, ↓↓ diminished in RLL. Pt c/o (R) upper chest pain c̄ deep inspiration. Abd flat, soft, non-distended. (B) radial + pedal pulses 2+, skin warm, dry, brisk cap. refill. + bowel sounds x 4 quadrants. (R) bicep IV c̄ 1/2 NS + 20KCl @ 50cc/hr, site ∅ s/sx infiltration or infection. Abd dsg d+i. Voiding dark yellow urine in urinal, qs. — [redacted] MAJ AN
1500	RR remains 40, shallow, appears unlabored. Will consult c̄ physician. — [redacted] MAJ AN
1555	Dr. [redacted] in to assess pt @ ~1505. STAT CBC + UA ordered and sent. Pt appears in no acute distress. WBC-WNL [redacted] MAJ AN
1600	Tylenol ii po given @ 1530 for T-101.2 oral @ 1450. Current temp is 101.5 oral, Dr. [redacted] aware. [redacted] MAJ AN
1900	VS @ 1855: BP-124/70, T-99.4 oral, P-112, RR-36, $Sp O_2$-98% on RA. Remains tachypneic, resp. are shallow and unlabored. Ate 10-20% of dinner. Ambulated to MWR → ER/Radiology → back x 2 c̄ Ø assistance. Had one BM, minimal amt of lt brown flakes/specks. [redacted] MAJ AN
1930	No changes in physical assessment noted since previous one (1450 today) — [redacted] MAJ AN

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Surg Note

25OCT03 0945

S: pt seen problems discussed (5 interpreter): walking 5 difficulty, urinating 5 difficulty (+) Flatus (+) BM, satisfied to oral pain meds: good control

O: VSS Tmax 100.1°

lungs: OA bilat

heart: RRS (w) chile

abd: soft NTND 5 mass, neg Incision dry (+) BS

ext: FPP - of strong

IMP: (1) POD #6 Enterotomy repairs, SB anast, appy

(2) FUO - responding

PLAN: (1) 24° more afebrile, consider d/c planning

(2) continue care

(3) ↑ chits

(b)(6)-2

25Oct03 1630 T= 101.5 Pt c̄

No Complaints

Lungs: ↓BS (R) Base

Abd: Soft. (+) Bowel Sounds. Wound Clean

CVA (-) WBC 7.9

Reviewed CXR Again - Still Residual Atelectasis/Infiltrate (R) Base

Will Cover c̄ po Levaquin

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 Oct 03 2100	T-100.4 oral. Cont. to use IS well, lifting all 3 balls, has poor cough, mainly clearing throat for mod-lg amt of white, frothy secretions. Denies further pain in RU chest c̄ deep inspiration. Poor po intake, UOP ~200 dark yellow urine per hour. — (b)(6)-2 — MJ AN
25 Oct 03 2245	T 101°, Bp 125/60, RR 32 (shallow), HR 120, SpO2 96%. - Small BM OOB to Chair for deep breathing + cough. Pt does not understand concept. Interpreter present and assisting unsuccessfully. I/S used c̄ better results. Tylenol 650 mg po gtube. Dressing to midline incision intact c̄ old drainage. IVF infusing c̄ difficulty. Will continue to encourage deep breathing and monitor temperature. — (b)(6)-2 — CPT/An — Lungs clear in upper lobes, diminished in middle + bases - oxygen cnp
26 Oct 03 @ 0100	Pt's Temp 99 orally. - OOB to BSC used I/S x 10. — (b)(8)-2 — CPT/An —
0200	- 130/65, HR 85, T 98.5, RR 28, Pox 100% - Pt c/o pain. Pt not sleeping @ this time. encourage cough + deep breathing. - [redacted] (b)(6)-2 — Medicated — (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.

POTUS (b)(6)-4

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

26 OCT 03 0700 Nursing Notes: VSS: T 97.8, Pulse ox 98%, BP 117/59, P 88, RR 16. Pt cooperative, A&OX3, pt ate 50% breakfast. Pt OOB in bedside chair, pt amb c̄ difficulty. 22 g IV cath in upper (R) arm patent & infusing D5 NS c̄ 20 mEq KCL @ 50 cc/hr c̄ difficulty, site c̄ redness, edema, or pain. Midline abdominal incision c̄ dressing CDI. Pt performed IS and cough/deep breathe. Will continue to monitor.

(b)(6)-2

26 Oct 03 1100 Surgery

- Pt without complaints. Ate 40-50% Breakfast
- NAD. Pleasant

Abd: Soft. ⊕ Bowel Sounds. WBC = 9.4

No Pain c̄ Palpation Hct = 27

Lungs: ↓BS (R) Base

- Stable. Temp down this a.m.

Still concerned c̄ Possible Pneumonitis

Still Concerned c̄ abd process/abscess, but abd exam at this time is Benign

- Continue po Levaquin. Cont to follow closely

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		NUMBER
	LAST	FIRST	

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.

Potter

(b)(6)-4

PROGRESS NOTES
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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26OCT03	11:00 - T98.6
26OCT03 1430	T 99.8 HR 98 BP 120/63 SaO2 98% R 18 Pt assessment complete. Pulses 2+ in all extremities BS Active x4. Pt voids quantity clear yellow urine. Lungs clear in upper lobes (R) remains diminished in (R) LL. Coughs, deep breathes and uses IS. [redacted] LCTAN
1645	Pt ambulated halls and to outside at his request. Sitting in chair @ bedside. [redacted] LCTAN
1720	T 99.2 @ pt back in bed. Consumed 50% of dinner [redacted] LCTAN
1900	T 100.4 @ IS complete 10x, Cough + deep breathe [redacted] LCTAN
2100	T 99.9 @ BP 118/61 HR 92 SaO2 98% R-18 [redacted] AN
2300	T 100.6 BP 123/60 HR 114 SaO2 99% RA RR18. Pt ambulated w/ difficulty using incentive spirometer 3 balls ↑ x10. (R) base cont ↓, BS x4 midline abd dsg d+i. Voiding qs. — [redacted] MAT/AN
27OCT03 0500	T 99.6 BP 117/66 HR 99 SaO2 98 RR16. Incentive spirometer done. [redacted] MAT/AN
27OCT03 0000	NAD. Negative Complaints. A&OX3 Lungs CTA (B) ✓ BS (R) base. ABD soft & nontender (+) BS X4 QUADS. 2+ peripheral pulses. [redacted] ILT, AN
27OCT03 0930	OOB to Chair. Ambulated in hospital Corridors & outside. AM care done. T 98.7 P 94 BP 119/65. NAD - [redacted] LCTAN.
27OCT03 1235	Released to NV's. Discharge instructions given to NV's (Medications & Drsg D's) HL dcd & Cath intact & no sxs of infection or infiltration NAD. [redacted] ILT AN.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
270C703	Surg Note POD # 8
0930	S: pt seen problems discussed thru interpreter.
	No pain. Ambulating, voiding, eating's difficulty.
	(When I asked him why he eats so little – is it type of
	foods or pain – he indicated he only eats small meal
	he is hungry + eats until full). (+) Flatus (+) BM.
	O: VSS Tmax 100.6 present T 98.7°
	lungs CTA bilat
	heart RRR w/ murmur
	abd soft NDNT w/ active BS. Incision dry, clean
	ext ⊘ ⊘ c/s strong pulses
	LAB: 136 | 97 | 8 (98 9.9) 9.5 (640
	4.1 | 25 | 1.0 27.8
	Imp: ① S/P ex lap, appy, partial SB resection, 1° re-anastomosis + small + large bowel enterotomy repairs POD # 8
	PLAN: ① ensure supplements
	② Ambien 10mg qhs prn sleep
	(b)(6)-2

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

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

Potus # (b)(6)-2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
19	OCT	03	0900

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: UNKNOWN

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: UNK

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0900 ARRIVAL

VITAL SIGNS			
TIME	0910		
BP	124/73		
PULSE	91		
RESP.	29		
TEMP.	—		
WT. (Child)	91%		

FLOW SHEET

CATEGORY (See reverse)
- [X] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME
MAINTAIN IV NS or LR TKO		
2nd IV NS or LR TKO		
FOLEY TO GRAVITY		
CBC, UA, T+S		
X-rays - CHEST, ABDO, PELVIS, SKULL		

ASSESSMENT/DIAGNOSIS: MULTIPLE FRAGMENTATION WOUNDS

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): GENERAL SURGERY
- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

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)

Adult ♂ local national of unknown age transferred from FSB at TALIFAR P sustaining injuries in grenade attack. Subject is alleged perpetrator of attack, arrived in custody of US personnel, will not speak or answer questions. Rec'd 4L crystalloid

AMPLE history - unobtainable - prior to transfer

urine 950ml

A - patent and maintainable
Nasal trumpet in place
B - Breath sounds symmetric
C - Small amount of bleeding from fragmentation wounds
BP normal, pulse ~ 100
D - GCS - 12 + (? sedation) PERL, MAE
E - Completely exposed, rolled

125 / 32.4 — 16.4 / 279

UA - SG = 1.022
large blood
20-30 RBC

GENERAL: Thin ♂ adult ♂ sedated, arousable but noncommunicative
SKIN: Warm + dry
HEENT: NC ē small penetrating wound (R) temporal area.
PERRL/EOMI/sclera clear
(L) nostril ē Nasal trumpet
TM's ~~[illegible]~~ not well visualized
Ø blood in EAC
Small penetrating wound (R) anterior neck

ABO/Pelvis - Fragments
Vic iliac crests
Skull - superficial fragments

LUNGS: CTAB ē W/R/R
CV: NRR ē (m) ~~[illegible]~~ S1/S2
CHEST: Numerous small penetrating wounds
ABDO: Soft/S/NT ē scattered small fragments

CXR - Ø PTX
N Films

RECTAL: Normal tone/NT - blood present no fragments

(CONTINUE ON SF 507, IF NEEDED)

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).

POTUS (b)(6)-4 (detainee)

(b)(6)-4

SIGNATURE OF PROVIDER (b)(6)-2

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

EXTREM - Fragmentation wound (L) shoulder
(L) Thumb ē open laceration at distal pad
(L) 3rd digit laceration sutured closed prior to arrival
ON: Foley in place, gloves ē contusion scrotum ē two small areas of penetrating trauma Ø scrotal edema

CTR, MC

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by: GSA and KCMR

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 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		(b)(6)-2	
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On		unknown Allergies	
Call Light Within Reach		X	
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 MAJ	ICU	19 OCT 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

		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		
	L										2				2								2		
	DORSALIS PEDIS R										2				2								2		
	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											ø				ø								ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)											✓				S1S2								✓		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)															NSR								SR		
SWAN GANZ CATHETER (Zeroed & calibrated)															ø										
ARTERIAL LINE (zeroed & calibrated)															ø										
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		
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																								
mult frag wounds	Surgical Wounds										✓				✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1																									
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
18 (b)(6)-2	(R) AC	18 OCT 03	CD1 Heplocked
18 (b)(6)-2	(L) AC	19 OCT 03	CD1

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

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

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

DATE: 19OCT03

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						3		
B. BEST VERBAL RESPONSE (5) Oriented (2) Garbled (4) Confused (1) No Response (3) Inappropriate Verbal Response										* 1		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										5		5		5		5						5		
GLASCOW COMA SCALE (A+B+C)										9		14		14		14						13		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — R										4+		3+		3+		3+						3		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) — L										4+		3+		3+		3+						3		
MOVEMENT (See Motor Function Scale at Top of Page) — RUE										4				4		4						4		
MOVEMENT — LUE										2				4		4						4		
MOVEMENT — RLE										N				4		4						4		
MOVEMENT — LLE										N				4		4						4		
GRIP (S) Strong (W) Weak (-) absent — R										/				W		W						W		
GRIP — L										/				W		W						W		
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										3				5								5		
BREATH SOUNDS — LUL										3				5								5		
BREATH SOUNDS — RLL										5				5								5		
BREATH SOUNDS — LLL										5				5								5		
BREATH SOUNDS — BOTH BASES										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) 2										✓				2L/NC								3L/NC		
OXYGEN DELIVERY DEVICE — FM (l/min)																								
OXYGEN DELIVERY DEVICE — NRBM (l/min)																								
ETT #_____ — ETT _____cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																								
INCENTIVE SPIROMETRY DONE																								
COUGH / DEEP BREATH																								
INITIALS										(b)(6)-2				(b)(6)-2								(b)(6)-2		

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																	
	100.5 ax	101	14	129/71	100%		90										4LNC
1100																	
1200	99.6 ax	102	14	117/71	100%												2LNC
1300																	
1400	100.5 ax	114	26	123/75	100%		94										2LNC
1500																	
1600	101.1 ax 101.2 ord	109	23	127/77	100%		96										RA
1700																	
1800																	
1900																	
2000																	
2100																	
2200																	
2300	99.9	126	26 ~~146~~ ~~150~~	143/80	95		105										RA
2400	99.1	139	20	147/72 ~~138/81~~	100		103										

OR & Recovery

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19 OCT 03	1030		Pt received from EMT accompanied by MP personnel and hospital guard. See flowsheet for complete assessment. Pt opens eyes spontaneously and with vigorous tactile stimulation. Not responding verbally & following commands. Spontaneous movement of 4 extremities noted. HOB ↑ 30° [redacted] MATN
	1130hrs		Dr [redacted] in to see pt, MP guard @ bedside [redacted] MATN
	1420		Pt moaning in bed c/o pain to LLQ bandages in place at sight. @ middle finger c̄ bandage covering stitches CDI. Multiple frag wounds on (R) LE and chest. Ecchymosis to penis but no hematoma visible. Opens eyes spontaneously and moves all extremities. Nasal trumpet in place to (R) nare. IV in (R) ac flushes well & s/sx infection/infiltration (L) AC infusing D5 1/2 NS @ 100cc/hr. Pt ignores interpreter when trying to talk to him. [redacted] MATN
	1630		Pt O_2 ↓ to RA sats 100%, guarding abd. c/o pain when he opens eyes. [redacted] MATN
	1640		Dr [redacted] and [redacted] @ bedside - will take pt to OR for exploration
20 19 OCT 03	2200 →		Assumed care of pt. VSS. Recovery completed by previous shift. Attempted to open eyes on verbal command. Lungs clr. HR 120's NST by monitor. Placed on 3L 2° O_2 sat 89%. NL ad incision x (R) hand dressings CDI. Pulses palp. All extremities. Numerous superficial wounds from shrapnel noted. Cont to monitor. IV (L) infusing at 125cc/hr via pump's s/sx of infiltration or infection. Continue to monitor [redacted] CSTAN
	~~2330~~	2330	HR to 140's. Phys notified. New Orders noted. Cont. to monitor.
20 OCT 03		0045	1st unit up. CBC shows Hct of 31 & H.3. HR remains 120's-130's. Cont. to monitor. [redacted] CSTAN

	INTAKE									OUTPUT						
	D5½NS	IVPB	NL	Pflex					Total	Urine	EBL	NGT			Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						8 HR	
0900																
1000																
1100	100/100	50/50														
1200	100/200									300/300						
1300	100/300	50								250/550						
1400	100/400	50														
1500	100/500															
1600	100/600									325/875						
8 HR	600	50							16 HR. 650	875					16 HR. 875	
1700	100/700									125/125						
1800																
1900	OK									OK						
2000																
2100	5000/5100									250/250	200/200					
2200			150							100/350						
2300		100	150/300	1000						100/450						
2400			150/450						6550	42/492					692	
8 HR									24 HR. 7100						24 HR 1567	

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 03
DOS	19 Oct 03
POD	1

24 HOUR DATA	
24 Hour Balance	
24 Hour Intake	7200
24 Hour Output	1567
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		(b)(6)-2
Monitor Alarms On			
ID Bracelet On			
Allergy Bracelet On			
Call Light Within Reach	N/A		N/A
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 SPT AN	ICU	20 Oct 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
- ☐ OTHER EXAMINATION Or EVALUATION
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT
- ☒ FLOWCHART
- ☐ OTHER(*Specify*)

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		
	RADIAL L		2						2		2				2				–				2		
	DORSALIS PEDIS R		2						2		2				2				–				2		
	DORSALIS PEDIS L		2						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			Ø						Ø		gen				✓				–				Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			✓						✓		✓				✓				–				R		
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NST						ST		ST				✓				–				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)																									
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		
BOWEL SOUNDS (active all quads)			✓						Ø		–				Ø				–				Ø		
NG / DOBHOFF PLACEMENT VERIFIED			✓						✓						✓				–						
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓						✓		✓				✓				–				✓		
VOIDING CLEAR, YELLOW URINE q.s.											✓				✓				–				✓		
SKIN INTEGRITY	No Breakdown																		–						
	Surgical Wounds		✓						✓		✓				✓				–				✓		
SCATTERED Puncture wounds	Rashes, Lac's, etc										✓				✓				–						
DRESSING (Dry & Intact: specify site below)																									
#1 MC Abd			✓						✓		✓				✓				–				✓		
#2 (R) hand			✓						✓		✓				✓				–				✓		
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) AC	18 ga	19 Oct	5 S/Sx of infection LRA @ 150cc/hr /1000
(R) FA/L	18 ga	19 Oct	5 S/Sx of infection /1000

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: 20OCTØ3

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				–				4		
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response			5						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				–				6		
GLASGOW COMA SCALE (A+B+C)			15						15		15				15				–				15		
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		3+						2+		2+				2				–				2		
	L		3+						2+		2+				2				–				2		
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4						4		4				4				–				4		
	LUE		4						4		4				4				–				4		
	RLE		4						4		4				4				–				4		
	LLE		4						4		4				4				–				4		
GRIP (S) Strong (W) Weak (-) absent	R		W						W		W				S				–				S		
	L		W						W		W				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				–				5		
	LUL		5						5		5				5				–				5		
	RLL		5						5		3				3				–				5		
	LLL		5						5		3				3				–				5		
	BOTH BASES		1						1		1				1				–				✓		
COUGH	NONE		✓						✓		✓														
	SPONTANEOUS																						✓		
	PRODUCTIVE																						✓		
	NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear																							2		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin																									
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min) RA								✓		✓				✓				–						
	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		(b)(6)-2				(b)(6)-2				(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	99.1	120	20	138/81	100		103										34 Nc
0200		112	20	130/76	95		98										RA
0300		116	22	137/84	95		103										RA
0400		111	16	135/78	97		102										RA
0500	99.9	114	25	136/83	95		103										RA
0600		111	19	139/74	97%		98										RA
0700		112	24	142/79	98%		101										RA
0800	98.5	109	~~97~~ 24	135/74	97%		99										RA
0900		111	22	142/71	100%		99										
1000		118	26	143/69	95%		98										
1100	100.9 (A)	123	34	127/66	95%		91										RA
1200																	
1300																	
1400		103	19	136-74	96		98										RA
1500																	
1600																	
1700																	
1800	97.6	104	20	131-76	100		97										
1900																	
2000																	
2100																	
2200	100.7	112	24	131/62	99%												
2300																	
2400																	

	INTAKE									OUTPUT						
	AR	IVPB	PRBC's						Total	Urine	NGT				Total	COMMENTS
0100	150 / 150	50	12 @300a							125 / 125						
0200	150 / 300									100 / 225						
0300	150 / 450									125 / 350						
0400	150 / 600									120 / 470						
0500	150 / 750	100 / 150								80 / 550						
0600	150 / 900															
0700	150 / 1050															
0800	150 / 1100	50 / 200								450 / 1000						
8 HR	1100	200							8 HR. 1300	1000					8 HR 1000	
0900	100 / 100															
1000	100 / 200									450 / 450						
1100	150 / 350	100 / 100								300 / 750						
1200	125 / 475									225 / 975						
1300	125 / 600									100 / 1075	200 / 200					
1400	125 / 725									200 / 1275						
1500	125 / 850									225 / 1500						
1600	125 / 975	100 / 200								300 / 1800						
8 HR	975	200							16 HR. 2475						16 HR. @3000	
1700	125 / 125	100 / 100								500						
1800	125 / 250									275 / 775						
1900	125 / 375									125 / 900						
2000	125 / 500									200 / 1100						
2100	125 / 625									100 / 1200						
2200	125 / 750									175 / 1375						
2300	125 / 875	100 / 200								40 / 1415						
2400	125 / 1000	100 / 300								300 / 1715						
8 HR	1000	300							24 HR. 3775	1715					24 HR 4715	

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20 Oct 03	0145		1st unit Blood finished. VSS. Will await to infuse 2nd unit ō AM CBC results. Continue to monitor. Currently on RA ō attempts by pt to take out NC. O2 Sat 94%. HR to 110's. Continue to monitor. [redacted]
20 Oct 03	0400		Eyes closed. Snoring softly. Ø pain meds ō MSO4 @ 2230. VSS ō blood. HR remains 110's. LR @ 150 cc/hr. Remains on RA. Continue to monitor. [redacted]
20 OCT Ø3	0600		Report received, assumed care of patient. Appears asleep, no distress noted. [redacted]
	0800hrs		AM care done, see flowsheet for assessment. Ⓡ hand soaked, dressing wrap changed dsd applied. Dsg's Δ'd to prevent skin dry. [redacted]
10/20/03	1115		Temp 100.2°(A). Medicated ō MSO4 6mg IVP. OOB To Chair ō assistance of 2 staff members. Tolerated well. See flowsheet for assessment [redacted]
Oct 20, 03		1400	Sleeping well WNL rises and falls of chest noted. Awake to sound of voices. ML ABD dressing intact with some drainage. Dressing to Bilat hands intact. NG to Ⓛ nare intact. Has some pain but refuses any med at this time. IV will be changed w/A. Understand my instruction about care w/A translator. has no question at this time. [redacted]
		1815	OOB to chair. Tolerated well need some rest. received 3cc MSO4 for c/o pain [redacted]
		1850	↓ in pain will cont to monitor pro orders [redacted]
		1945	Return to bed tolerated well. Status comfortable at this time. Will cont to monitor [redacted]
20 OCT Ø3		2200	resting @ this time, assessment completed ō Ø S/S of pain showed, Ø S/S of resp distress. All dressing CDI, Ø Bowel sounds heard @ this time [redacted]

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19Oct03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+425
24 Hour Intake	4900
24 Hour Output	4475
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	N/A	N/A	
Side Rails Up			
Bed in Low Position		(b)(6)-2	

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU	21Oct03

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

		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		2				2				2				2				2						
	DORSALIS PEDIS R		2				2				2				2				2						
	DORSALIS PEDIS L		2				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			Ø				Gen				Gen				Ø				Ø						
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			NST				✓				✓				✓				✓						
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		✓																						
	PAIN SCALE (1-10)										✓				min	+		+				+			
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat (1) Distended		2				2				2				2				2						
BOWEL SOUNDS (active all quads)			Ø				Ø				Ø				+LLQ				X						
NG / DOBHOFF PLACEMENT VERIFIED			✓				✓				✓				✓				✓						
RESIDUAL ASSESSED															N/A										
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 ABD - CDI			✓				✓				✓				✓				✓						
#2 (R) thorax CDI			✓				✓				✓				✓				✓						
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
(L) AC	18G	19 OCT 03	CDI / 0600 / 1000 / 1400 mf
(R) FA	18G	19 OCT 03	CDI / 0600 / 1000 D/C'd

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: 21 OCT 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			4				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				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				6						
GLASCOW COMA SCALE (A+B+C)			15				15				15				15				15						
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-)	R		2												4+				4+						
	L		2												4+				4+						
MOVEMENT (See Motor Function Scale at Top of Page)	RUE		4				4				4				4				4						
	LUE		4				4				4				4				4						
	RLE		4				4				4				4				4						
	LLE		4				4				4				4				4						
GRIP (S) Strong (W) Weak (-) absent	R		S				W				W				4				4						
	L		S				W				W				4				4						
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				5				5/1				5/1						
	LLL		5				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			5								5				X				1						
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin											3				3				2						
VENTILATOR	Vt																								
	FiO2																								
	RATE (SIMV/CMV)																								
	PEEP / CPAP																								
	PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE	NC (l/min)						RA				RA				RA				RA						
	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				(b)(6)-2				(b)(6)-2				(b)(6)-2						

(5)(6)(2)

VITAL SIGNS

(5)(6)(2)

TIME	T	P	R	B/P	SAT	A-line	MAP	PA	RA	PCW	CO	CI	PVR	SVR	ICP	CPP	COMMENTS
~~0100~~ 0200	~~100.3~~ 100.3	~~113~~ 113	~~26~~ 26	~~130/66~~ 130/66	~~98~~ 98	[redacted]	~~90~~ 90										[redacted] ~~RA~~ RA, NAD
0300																	
0400																	
0500																	
0600	99.9 (A)	106	20	130/58	95		85										
0700																	
0800																	
0900																	
1000	100.9 (A)	121	38	142/63	96		89										
1100																	
1200	100.0 (A)																
1300																	
1400	100.8 (A)	110	20	119/64	98		87										
1500																	
1600																	
1700																	
1800	101.6 (O)	104	28	127/67	98		89										
1900																	
2000	101.6 (O)																
2100																	
2130	101.0 (O)																
2200	100.4	105	20	131/61	99		88										
2300																	
2400																	

	INTAKE									OUTPUT						
	DS N5 20 KCL	IV PB							Total	Urine	NG				Total	COMMENTS
0100	125 125									100 100						
0200	125 100									100 200						
0300	125 375															
0400	125 500															
0500	125 625									375 375						
0600	125 750									100 875						
0700	125 875									↓						
0800	125 1000									400 1275						
8 HR	1000								8 HR. 1000	1275					8 HR 1275	~~275~~
0900	125 125															
1000	125 250	100 100								325 325						
1100	75 325									↓						
1200	75 400	100 200								225 550						
1300	75 475									↓	300 300					
1400	75 550									125 675						
1500	75 625															
1600	75 700	100 300								250 925	300 600					
8 HR	700	300							16 HR. 2000	925	600				16 HR. 2800	~~800~~
1700	75 75	100 100								200 200						
1800	75 150									100 300	200 200					
1900	75 225									200 500						
2000	75 300									75 575						
2100	75 375									100 675	200 400					
2200	75 450									75 750	150 550					
2300	75 525	100 200								25 775	150 700					
2400	75 600	100 300								150 925	50 750				1675	
8 HR	600	300							24 HR. ~~2900~~	925	750				24 HR 4475	

4900

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21 Oct 03 1400 MJ		1400	Pt used IS c̄ encouragement, able to lift ball #2 x 3. C+DB p̄ IS c̄ abd splinting → thick, dark brown sputum, looks like dried blood. States has only slight pain in abd per interpreter. NG → LIS c̄ dark green drainage. (L) AC IV patent ∴ S/Sx infiltration or infection. [redacted] MJ AW
21 Oct		1900	% abd pain x2 this shift. 4mg MSO4 IVP given @ 1645 and 1845. Pt appears able to rest p̄ doses. Hypoactive bowel sounds heard in LUQ and LLQ; Ø heard on (R) abd. Midline abd dsg c̄ no new drainage this shift; dsg Δ'd per Dr. [redacted] Temp @ 1800 was 101 oral → Tylenol supp given. [redacted] MJ AW
		1930	Pt ambulated to EMT entrance and back with minimal assistance; sat in chair @ bedside. Cont to cough up mod-lg amt frothy, white secretions.
21 Oct		2040	Dr. [redacted] notified of pt temp (101.8 oral). Lung sounds ↓↓ diminished RLL → NT stimulation c̄ 14 Fr catheter thru (R) nare → 2-3 deep coughs for small amt thick, yellow, blood-tinged secretions. Do IS q1° while awake and q2° when sleeping. Per X-ray, NG → in duodenum, pulled back ~6 in by Dr. [redacted] NG continues to drain lg amt dark green fluid. [redacted] MJ AW
		2215	Ø C/O pain up to chair ∴ difficulty, Ø S/S of resp distress will cont to monitor pt [redacted] CE
		2300	C/O pain after return to bed; pain medication given (see MAR) will cont to monitor [redacted]
		2330	sleeping @ this time [redacted] CP

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 03
DOS	
POD	

24 HOUR DATA	
24 Hour Balance	+650
24 Hour Intake	3405
24 Hour Output	1755
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	N/A	N/A	
Side Rails Up			
Bed in Low Position			

PREPARED BY (Signature and Title)	Department/Service/Clinic	DATE
(b)(6)-2 LPN	ICU	22 Oct 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

		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					1 3 8							1 3 8								1 3 8		
EDEMA			Ø					Gen							Gen								Ø		
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R					✓							✓										
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR					ST							SR								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		
BOWEL SOUNDS (active all quads)			Ø					Ø															LOC		
NG / DOBHOFF PLACEMENT VERIFIED								✓																	
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT			✓					✓																	
VOIDING CLEAR, YELLOW URINE q.s.			✓					✓															✓		
SKIN INTEGRITY	No Breakdown							✓																	
	Surgical Wounds																								
BLE surgical	Rashes, Lac's, etc														✓										
DRESSING (Dry & Intact: specify site below)																									
#1 ABD - CDI			✓					✓							✗								✓		
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
L AC	18g	19 Oct 03	C D I / 0700
NGT G	(D) NARES	19 OCT 03	Patent, latact to L/WS / 0700 D/C'd 10/22 10:00

PUPIL SIZE	PUPILS		MOTOR FUNCTION	CHART CODES
1 mm	=	Equal	0 = No Movement	Present ✓
2 mm	R	Reactive	1 = Slight Flicker/ Trace of Contraction	Not Applicable /Absent (blank)
3 mm	NR	NonReactive	2 = Active (Gravity Eliminated)	
			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 (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		
GLASCOW COMA SCALE (A+B+C)		15					15							15								1		
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		4					4							4								4		
LUE		4					4							4								4		
RLE		4					4							4								4		
LLE		4					4							4								4		
GRIP (S) Strong (W) Weak (-) absent R		5					5							5								5		
GRIP L		5					5							5								5		
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							1								1		
LLL		5					5							5								1		
BOTH BASES		5					5							✓								1		
COUGH NONE		✓																						
SPONTANEOUS		✓												✓								✓		
PRODUCTIVE														✓								✓		
NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		2					1/5							1,5								2		
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		3					3							3								3		
VENTILATOR Vt																								
FiO2																								
RATE (SIMV/CMV)																								
PEEP / CPAP																								
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)							4/4																	
FM (l/min)							4																	
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							(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																	
0200	98.5	101	20	128/67	99%		89										
0300																	
0400																	
0500																	
0600																	
0700	101.8(A)	121	18	133/68	95		90										
0800																	
0900	101.8(O)	~~111~~ ERROR	20	130/63			89										
1000																	
1100																	
1200	101(O)	111	20	130/63			89										
1300																	
1400	100.1(O)	99	17	130/60	97												
1500																	
1600																	
1700																	
1800	102.4(O)	118	24	134/70	98%												
1900																	
2000	101.2(O)																
2100																	
2200																	
2300																	
2400																	

	INTAKE								OUTPUT					
	NS 20KCL	IVPB	PO					Total	Urine	NGT				Total	COMMENTS
0100	75 / 75								50 / 50	0					
0200	75 / 150								100 / 150	250 / 250					
0300	75 / 225								200 / 350	0 / 250					
0400	75 / 300								130 / 480	0 / 250					
0500	75 / 375	100 / 100							50 / 600	0 / 250					
0600	75 / 450								↓						
0700	75 / 525								275 / 655						
0800	75 / 600	50 / 150							100 / 755						
8 HR	600	150						8 HR. 750	755	250				8 HR 1005	-255
0900	75 / 75								75 / 75						
1000	75 / 150														
1100	75 / 225								125 / 200						
1200	100 / 325														
1300	100 / 425														
1400	100														
1500	100 / 425														
1600	100 / 725							725	75 / 425						post foley D/C Xrd
8 HR	725							16 HR. 1475	425					16 HR.	b&D
1700	100 / 100								275 / 275						
1800	100 / 200														
1900	100 / 300	100 / 100													
2000	100 / 400		30 / 30						425 / 700						
2100	100														
2200	100														
2300	100														
2400	100 / 500							930	300						1075
8 HR								24 HR. 3405						24 HR	1755

MEDICAL RECORD | NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
22OCT03		0215	- c/o pain via interpreter, pain medication given (see MAR) will continue to monitor pt
22OCT03		0715	Temp 101.8°C(A). IS used c̄ consistant elevation of 2 balls. Medicated c̄ Tylenol 650mg i̇ PR. & Ativan 4mg IVP. See flow sheet for assessment. [redacted] ICT, RN
22OCT03		1025	OOB to chair over 1 hr. Ambulated to HWR & back. Tolerated well. Continue frequent IS. Able to get third ball up c̄ coaching. Ineffective cough. N-T suction per Dr [redacted] RTD TO BED. NGT D/c'd. [redacted] ICT, RN
		1400	Assumed care. Pt resting comfortably in bed. Encouraged IS and deep cough. Pt c/o "clear" c̄ cough. PT induced cough c̄ N-T sxn. Abd drsg. c̄ scant serous drainage on upper 2/3, sm. amt serosanguinous drainage on lower 1/3. Will continue to monitor. [redacted] RN
		1430	Pt c/o mild pain on lateral side of R foot. Encouraged pt. to move foot thru entire ROM. [redacted] RN
		1500	lung sounds improved p̄ PT deep sxn and deep cough. Pt sitting @ 90° in bed. [redacted] RN
		2000	Pt ambulated to EMT doorway thru down to DEAC and back s̄ difficulty. Pt continues use c̄ IS and pulls enough air to raise all 3 balls. Groaning crying. Pt sat @ bedside for 1°. New IV started in R FA. IV in L AC d/c'd r/t leaking and signs of phlebitis. [redacted] RN
		2100	D [redacted] @ bedside, N-T suction complete, light cough produced bloody sputum. IS complete [redacted] RN

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	19 Oct 03
DOS	23 OCT 03
POD	

24 HOUR DATA	
24 Hour Balance	+1100
24 Hour Intake	2000
24 Hour Output	- 900
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
(b)(6)-2	ICU	23 Oct 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

		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	RADIAL R		2				2				2				2								2	2	
4) Bounding																									
3) Full	L		2				2				2				2								2	2	
2) Normal	DORSALIS R		2				2				2				2								2	2	
1) Faint	PEDIS																								
0) Absent	L		2				2				2				2								2	2	
SKIN			1				1				1				1									1	
(1) Dry (4) Cool (7) Jaundiced			3				3				3				3									3	
(2) Clammy (5) Flushed (8) Color Normal			8				8				8				8									8	
(3) Warm (6) Cyanotic (9) Pale																									
EDEMA			Ø				Ø				Ø													Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)			R				✓		(b)(6)(2)		✓				✓									✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)			NSR				[redacted] ST				ST				ST									SR	
SWAN GANZ CATHETER (Zeroed & calibrated)			~~[illegible]~~																						
ARTERIAL LINE (zeroed & calibrated)																									
HYGIENE	BED BATH							✓																	
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST																								
	BSC		✓																						
	DANGLE																								
	CHAIR						✓				✓												✓		
POSITIONED	RIGHT																						S		
	LEFT																						C		
	SUPINE																						I		
	HOB 30 DEGREES		✓												✓								E		
FALLS PROTOCOL INITIATED																									
PROTECTIVE DEVICES (Refer to FHMDA OP132-26)																									
PAIN	PAIN FREE						5/10	6/10			✓				✓ 7/10								PF		
	PAIN SCALE (1-10)						↓	↓								↓									
PCA/PCEA IN USE (Refer to FHMDA OP132-7)																									
ABDOMEN	(2) Soft & Flat		2				2	2			1				2								2		
	(1) Distended																								
BOWEL SOUNDS (active all quads)			low				hyp				hypo				Hypo								hy		
NG / DOBHOFF PLACEMENT VERIFIED																									
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT																									
VOIDING CLEAR, YELLOW URINE q.s.							dark				dark												comc		
SKIN INTEGRITY	No Breakdown																								
	Surgical Wounds		✓				✓				✓				✓								✓		
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 INCISION ABD Clnldline			✓				✓				✓				✓								✓		
#2																									
#3																									
																							(b)(6)-2		

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18G	R FA	220ct03	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: 23 OCT 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									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+	
L		2+				2+				2+				+2									3+	
MOVEMENT (See Motor Function Scale at Top of Page) RUE		4				4				4				4									4	
LUE		4				4				5				4									4	
RLE		4				4				4				4									4	
LLE		4				4				5				4									4	
GRIP (S) Strong (M) Weak (-) absent R		S				S				S				S									N	
L		S				S				S				S									N	
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		1				1				1				1									1	
LLL		1				1				1				1									1	
BOTH BASES						1				1				1									1	
COUGH NONE																								
SPONTANEOUS		✓				✓				✓				✓									✓	
PRODUCTIVE		✓				✓				✓				✓									✓	
NONPRODUCTIVE																								
SPUTUM COLOR (5) Tan (4) Green (3) Pink (2) Yellow (1) Clear		2				5				5				5									5	
SPUTUM CONSISTENCY (3) Thick (2) Frothy (1) Thin		3				3				3				3									3	
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				(b)(6)-2				(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																	
0200	98.9	110	16	116/58	99%												
0300																	
0400																	
0500																	
0600	100.6	109	16	125/68	97%												
0700																	
0800																	
0900																	
1000	100.6	109	18	116/59	96%												
1100																	
1200																	
1300	[redacted] (5/6/2) ~~100.5~~																
1400	100.8	105	16	125/63	97%												
1500																	
1600																	
1700	101.3																
1800																	
1900	99.6	101	16	124-70	98%												
2000																	
2100																	
2200																	
2300	98.3	94	16	120/76	99%	—	93										
2400																	

	INTAKE								OUTPUT					
	NS20KCL	PO	IVPB					Total	Urine					Total
0100	100													
0200	100													
0300	100													
0400	100								100					
0500	100													
0600	100 / 600	90 / 90	100 / 100											
0700	100 / 700								175 / 275					
0800	100 / 800		50 / 150											
8 HR	800	90	150					8 HR. 1040						8 HR 275 +
0900	100 / 100													
1000	100 / 200													
1100	100 / 300								75 / 75					
1200	100 / 400		100 / 100											
1300	100 / 500								100 / 175					
1400	100 / 600								150 / 325					
1500	100 / 700													
1600	100 / 800		50 / 150											
8 HR	800		150					16 HR. 950	325					16 HR. 600 +
1700	100													
1800	100 / 200		100											
1900	100 / 300													
2000	100													
2100	100													
2200	100													
2300	100		50 / 150						300					
2400	100		100 / 250											900 +
8 HR	800		250					24 HR 2000						24 HR 900 +

COMMENTS

(b)(2)(b)

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	0200		resting @ this time will continue to monitor pt. (b)(6)-2
23OCT03	0600		Pt cooperative & alert & oriented X3. VS: Tmax 100°, encouraged pt to cough, deep breath & ↑ fluid intake. Pt attempted to eat Jello, finished <20% & drank water ≅ N or V; pt c/o abd pain from sitting up in chair during breakfast, pain scale 3/10. Pt making effort to cough up dark tan & brown sputum. Pt urinated 200 cc dark yellow urine, pt encouraged to ↑ fluids; Pt cooperative and verbalized understanding. 18 g IV in (R) FA patent & infusing maintainence IV fluids. Will continue to monitor. (b)(6)-2
23OCT03	0900		Pt c/o pain 6/10 abdominal pain; medicated pt c̄ MSO4 4mg IV per prn pain order. Pt received immediate relief & asked to stay in chair at bedside instead of bed. Will continue to monitor pt. (b)(6)-2
		1445	M.D at the bedside doing NT suction tolerating well. NAD encourage coughing and Deep breathing. See DA Form 4700 for assessment. Will con't to monitor per orders. (b)(6)-2
		1640	↑ OOB walking hall NAD. Doing well. Needed very little assist just getting out of bed. ↑ Sitting in chair and working on Is. Will con't to monitor per orders (b)(6)-2
		1840	Back to bed NAD doing well. will con't to monitor per order. (b)(6)-2
		2110	Sleeping c̄ eyes closed resp and heart sounds noted. (b)(6)-2

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care/treatment or discharge from an inpatient hospital stay.

SECTION I
TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 19 Oct 03
2. ADMITTING/DIAGNOSIS: Abd Shrapnel Wounds
3. PERTINENT LAB, X-RAY, FINDINGS:
~~Small Bowel Injur~~
CXR Normal Except Elevated Right Diaphram
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
Exp Lap 19 Oct with Repair of Small Bowel Injury X2 and Sigmoid Colon Injury X 1
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
Shrapnel Wounds to Abdomen with Small & Large Bowel Injury
6. ACTIVITY: As Tolerated
7. DIET: Regular
8. MEDICATIONS:
☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
Levaquin 500mg twice a day until gone
Zantac 150mg twice a day until gone
Tylenol ~~650mg~~ 325mg One or Two every 4° As Needed for Pain
9. INSTRUCTIONS (To Home Health Providers, Patient, etc):
Drink Fluids - Extra
10. DISCHARGING PROVIDER:
(b)(6)-2 (b)(6)-2
(Printed Name)

SECTION II
TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ HOME ☐ DUTY ☒ OTHER MP's
☒ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER
2. ACCOMPANIED BY: ☐ FAMILY ☐ FRIEND ☒ OTHER MP's
3. PATIENT EDUCATION:
Completed and patient prepared for home care. ☒ YES ☐ NO
If no, explain:
Patient ☒ states ☐ demonstrates understanding of home care needs.
Printed educational materials provided:
4. Clinical outcomes met and post-discharge/release referrals made.
☒ YES ☐ NO If no, explain:
5. If transferred to another health care facility, report called to nurse.
☐ YES ☐ NO If no, explain:
6. NUTRITION CARE - Comments:
Regular
7. MEDICATIONS:
Explained by: ☒ NURSE ☐ PHYSICIAN ☐ PHARMACIST → TO MP's
Printed medication literature provided. ☐ YES ☒ NO
~~Patient~~ MP's states understanding of prescribed medications. ☒ YES ☐ NO
8. EQUIPMENT/SUPPLIES PROVIDED:
4X4's & 2X2's TAPE
CHANGE DRESS EVERY 1-2 days.
IF increased redness or drainage Notify CSH
9. FOLLOW-UP APPOINTMENTS, POINT OF CONTACT & PHONE:
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
CSH or unit MEDIC

PATIENT IDENTIFICATION
POTUS (b)(6)-4

(b)(6)-2
BY:
ICT, AN 10/27/03 1230
(Signature and Title) (Date and Time)
A COPY OF AND UNDERSTAND THESE
INSTRUCTIONS.
(b)(6)-2
27 OCT 03 1231
(Signature) (Date and Time)

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

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 Carry BY [illegible]

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

3. DATE 15/10/03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: will not respond to interrogation any questions, or [illegible] being us next to him

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2	RELIEF SCRUB	Sgt (b)(6)-2 1245-EDC
ASSIGNED CIRCULATOR	CDT (b)(6)-2	RELIEF CIRCULATOR	Maj (b)(6)-2 745-EDC

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: no nicks or cuts noted

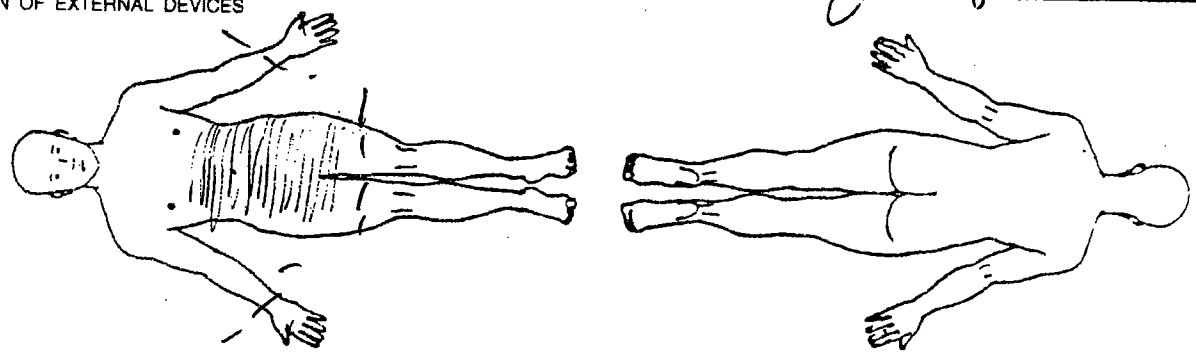
PREP SOLUTION *(Specify)* Betadine SOL

SITE: Abdomen BY WHOM: CDT Maj

SITE: BY WHOM:

COMMENTS: no pooling 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				(b)(6)-2	(b)(6)-2
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;)*

Potus # (b)(6)-4

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

☒ ESU NO: 077934 52/50

GROUND PAD: BRAND Valleylab

LOT NO: 69671 05/07

☐ 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.

MEDCOM - 2468

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

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. #16 Fr Foley	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

2x2s
4x8s
tape

19. ADDITIONAL INFORMATION

(b)(6)-2

20. OPERATION(S) PERFORMED

Ex lap, appy, part sm bowel resection, anastamosis sm & lg bowel enter. repairs —

21. PATIENT TRANSFERRED TO ICU TIME See D METHOD litter + safety strap

22. REG (b)(6)-2 Major

REVERS

MEDCOM - 2469

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 24 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1130	clear liquids	500	500
1800	Jello	50	550
1800	Water	120	670
2030	Gatorade	200	870
2255	jello	50	920

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0200	1000	D5 NS c̄ 20 KCL	400	0600	400
0530	100	primaxin	100	0600	500
0730	50	Zantac	50	0815	550
1130	100	Primaxin	100	1230	650
1400	800	D5 NS c̄ 20KCl	800	1400	1450
1600	50	Zantac	50	1630	1500
1800	100	Primaxin	100	1900	1600
2200	400	D5 ~~1/4~~ NS c̄ 20kcl	400	2200	2000
2320	50	Zantac	50	2350	2050

~~IRRIGATIONS~~ ~~(N.G. Bladder, etc.)~~ IV Cont.

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE +2970

USAPPC V1.00

Potus # (b)(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0145	200	200			
0330	400	600			
1400	700	1300			
1600	250	1550			
1800	250	1800			
2130	300	2100			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0100	light	mucoidy	sm	
0900	light brown	soft stool	Mecl	
1345	"	"	"	
1800	light brown	hard formed	sm	

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

Potus # (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 25 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1600	Gatorade	90	90
1800	Gatorade	60	150

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0020	100	Primaxin	100	0100	100
0545	100	Primaxin	100	0615	200
2200	400	D5NS E 20 KCl	400	0600	600

IRRIGATIONS (N G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE [redacted] 750

(b)(6)(2)

USAPPC V1.00

POTUS #: (b)(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0215	400	400			
0420	350	750			
1500	225	975			
1555	120	1095			
1650	200	1295			
1830	~200	1495			
2030	225	1720			
2300	300	2020			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1830	lt brown	flakes/specks	small	min
2245	green	smear	small	small

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS
TOTAL HOURS COVERED
DATE 20Oct03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0605	Water po	100cc	100cc
0800	Water PO	120cc	220cc
1000	Water	90cc	310cc
1400	Water	240	550
1600	Water	240	790
1700	Soda	300	1090
2100	Water	240	1330

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000	1000	D5NS ō 2KCL	300		300

IRRIGATIONS (N.G. Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE 1630

USAPPC V1.00

Potus #

(b)(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0230	300	300			
0930	375	~~375~~ 675			
1100	375	1050			
1530	350	1400			
1600	350	1750			
1700	275	2025			
1800	250	2275			
1900	300	2575			
2030	250	2825			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1330	Brown	Semi-solid	Sm	X1

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT 2825

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0300	1000	1000			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

POTUS (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

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

Physician: Dr.	Ward: (b)(6)-2	X STAT / Routine	Date and Time: 19Oct03 1020	Reported by: (b)(6)-2	Date and Time: 19Oct03

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		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	Yellow	Straw/Yellow
	Clarity	s/tcldy	Clear
	Glucose	250	Negative
	Bilirubin	neg	Negative
	Ketone	neg	Negative
	SG	1.022	1.010-1.025
	Blood	large	Negative
	pH	6.0	5.0-8.0
	Protein	neg	Negative-Trace
	Urobili	Norm	Negative
	Nitrite	neg	Negative
	Leuko	neg	Negative

Urine Microscopic

	WBC	0-3	Epi rare
	RBC	20-30	Mucus Trace
	Bacteria	light	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	O	POS

HCG

	Urine		Negative
	Serum		Negative

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	12.5 *	4.8-10.8 x10(3)/uL
	RBC	3.63 *	4.2-6.1 x10(6)/uL
	Hgb	11.4 *	12.0-18.0 g/dL
	Hct	32.4 *	35.0-60.0%
	MCV	89.3	80.0-99.0 fl
	MCH	31.4 *	27.0-31.0 pg
	MCHC	35.1	33.0-37.0 g/dL
	Plt	279	130-400 x10(3)/uL
	LY%	4.7 *	15.0-55.0%
	LY#	0.6 *	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: CBC, Type screen, UA

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	RANK	SSN
(b)(6)-4	N/A ICU	NA	(b)(6)-4

Physician:	Ward:		STAT	Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU	X	Routine	19Oct 1530	(b)(6)-2	19Oct03 1537

Chemistry (i-STAT)

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		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:		

Other: CBC

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

Hematology

X	TEST	RESULT	REF. RANGE
	WBC	14.2	4.8-10.8 x10(3)/uL
	RBC	4.08	4.2-6.1 x10(6)/uL
	Hgb	11.7	12.0-18.0 g/dL
	Hct	36.5	35.0-60.0%
	MCV	89.5	80.0-99.0 fl
	MCH	28.7	27.0-31.0 pg
	MCHC	32.1	33.0-37.0 g/dL
	Plt	270	130-400 x10(3)/uL
	LY%	5.8	15.0-55.0%
	LY#	0.8	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

STANDARD FORM 545 Rev.
10-75 545-108

LABORATORY REPORT DISPLAY

URINALYSIS

TEST(S)		
SPECIMEN TAKEN		
DATE 20 OCT 03	TIME 0010 A.M. P.M.	
RESULTS	REQUESTED	(X)
	ROUTINE	
13.7	~~COLOR~~ WBC	
3.78	~~SPECIFIC GRAVITY~~ RBC	
1.63	~~UROBILINOGEN~~ Hgb	
34.4	~~OCCULT BLOOD~~ Hct	
90.9	~~BILE~~ MCV	
30.0	~~KETONES~~ MCH	
33.0	~~GLUCOSE~~ MCHC	
235	~~PROTEIN~~ plt	
5.4	~~pH~~ L/D	
	~~MICROSCOPIC~~ L/H	
0.7	~~WBC~~ L/H	
	RBC	
	EPITH CELLS	
	WBC (CASTS)	
	RBC (CASTS)	
	HYALINE (CASTS)	
	GRANULAR (CASTS)	
	BACTERIA	
	CRYSTALS	
	MUCUS	
	NITRITE	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

REMARKS: CBC

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

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

REPORTED BY: b(6)-2

MD DATE: ECH 20 OCT 03 0035

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

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

SPECIMEN SOURCE: ☒ ROUTINE ☐ OTHER (Specify)

LAB. ID NO.

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

PATIENTS MED. RECORD

HEMATOLOGY

TEST(S)		
SPECIMEN TAKEN		
DATE 20 OCT 03	TIME 0500 A.M. P.M.	
RESULTS	REQUESTED	(X)
4.14	RBC COUNT	
12.9	HEMOGLOBIN	
37.4	HEMATOCRIT	
90.4	MCV	
31.2	MCH	
34.5	MCHC	
12.2	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
234	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	PT % ACTIVITY	
	PT RATIO	
	SICKLING TEST	
5.2	LE PREP L/H	
0.7	L/H	

REMARKS: CBC

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

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

REPORTED BY: (b)(6)-2

MD DATE: ECH 20 OCT 03 0500

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

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

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

LAB. ID NO.

SPECIMEN/LAB RPT. NO.

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

PATIENT'S MED. RECORD

Pathus

ICU

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.

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 7
- ☐ PARASITOLOGY (SF 552)
- ☐ IMMUNOHEMATOLOGY (SF 556)
- ☐ ASSORTED FORMS
- ☐ OTHER (Specify)

MOUNTED ON STRIPS 1, 4 AND 7
- ☐ MICROBIOLOGY I (SF 553)
- ☐ MICROBIOLOGY II (SF 554)
- ☐ MISCELLANEOUS (SF 557)
- ☐ ASSORTED FORMS

General Services Administration and Interagency Committee on Medical Records ICMR 201-45.505

LABORATORY REPORT DISPLAY

MEDCOM - 2479

GPO—1991—304—610

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

ICU

SPECIMEN/LAB. RPT. NO.

CHEM I

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

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

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

DATE 20 Oct 03

LAB. ID. NO.

REMARKS

Chem 12 0540h

546-107

TEST(S)																																	
SPECIMEN TAKEN																																	
DATE 20 OCT 03	TIME 0500	A.M. (X) P.M.	REQUESTED	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)					
RESULTS				132	10	0.9							7.9*	4.4*	2.5*	3.4						2.5*		<20*		18				74* ALT	91* AST		

CHEMISTRY I
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

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

CHEM I

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Male

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

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

REPORTED BY MD TECH

DATE

LAB. ID. NO.

REMARKS

BMP (all exp. Na & K)

546-107

TEST(S)																																	
SPECIMEN TAKEN																																	
DATE 20 OCT 03	TIME 1650	A.M. P.M. (X)	REQUESTED	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)					
RESULTS				122	10	0.6		129	4.8	93	25		8.3																				

CHEMISTRY I
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

Potus

(b)(6)-4

ICU

CHEM I

URGENCY: [X] ROUTINE; TODAY [ ]; PRE-OP [ ]; STAT [ ]

PATIENT STATUS: [X] BED; [ ] AMB; OUTPATIENT [ ]; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [X] BLOOD; [ ] OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

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

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

REPORTED BY (b)(6)-2 MD

DATE 21 Oct 03

LAB. ID. NO.

REMARKS

Met 8, BMP c Mg & PO4

0530 HR

TEST(S)																																									
SPECIMEN TAKEN	DATE 21 OCT 03	TIME 0530	A.M. / P.M.	REQUESTED (X)	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)												
RESULTS					133	16	0.8		126	4.0	92	27		7.8								154																			

548-107

CHEMISTRY I
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FIRMR (41 CFR) 201-45.505

Potus

(b)(6)-4

ICU

HEMATOLOGY

URGENCY: [X] ROUTINE; TODAY [ ]; PRE-OP [ ]; STAT [ ]

PATIENT STATUS: [X] BED; [ ] AMB; OUTPATIENT [ ]; [ ] NP; [ ] DOM

SPECIMEN SOURCE: [X] VEIN; [ ] CAP; [ ] OTHER (Specify)

PATIENT'S MED. RECORD

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

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

REPORTED BY (b)(6)-2 MD

DATE 21 Oct 03

LAB. ID. NO.

REMARKS

CBC

0545 HR

TEST(S)																																									
SPECIMEN TAKEN	DATE 21 OCT 03	TIME 0530	A.M. / P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	P T T	CONTROL	PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP							
												WBC DIFF AND BLOOD CELL MORPH																												
RESULTS					2.94	9.1	26.6	90.6	30.8	34.0	6.2			85%								195													6.5	4+					

549-107

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

DATE 10/22/03 | TIME 1040

Physician (b)(6)-2

Clinic/Ward/UCA ICU

☐ Clean Catch ☒ Catheterized

☐ Routine
☐ Today
☒ STAT

Patient ID

Urine Chemistry

Complete

Glu Neg pH 8.5
Bil Neg Pro 30
Ket small Uro Neg
SG 1.010 Nit Neg
Blood mod Leu Neg

POTUS

(b)(6)-4

UA

Color Amber
Appearance Clear
Clinitest
Acetest
Ictotest
SSA

Microscopic

Casts /LPF
Type
WBC 0-1 /HPF
RBC 0-1 /HPF
Crystals
Epi Cells /HPF
Type
Yeast
Trichomonas
Bacteria light
Mucous
Other

Clinical Data:

Reported By:

(b)(6)-2

Date: 22 Oct 03

Note: Micro exam only when abn. chem. found or upon special request.

Normal Values

Color: Straw, Yellow, Amber
Specific Gravity: 1.003-1.030
Urobilinogen: 0.1-1.0 EU/dl
pH: 4.6 — 8.0
WBC: 0—5/HPF
RBC: 0-3/HPF
Epi: 0—5/HPF
Others: Negative

TEST(S)
SPECIMEN TAKEN
DATE 22 Oct 03 TIME 0415 A.M. P.M.
REQUESTED

RESULTS

Glu - 113
BUN - 9
CRE - 0.7
CK - 1201
Na - 121*
K - 3.9
Cl - 99
tCO2 - 24
Ca - 8.2

REMARKS

met 6 ml cite 8 ml BMP
(b)(6)-2

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

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

REPORTED BY (b)(6)-2

MD TECH

DATE 22 Oct 03

LAB ID NO.

MISC

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

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

SPECIMEN SOURCE (Specify) Blood

SPECIMEN/LAB RPT. NO

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

557-107

PATIENT'S MED. RECORD

POTUS #

(b)(6)-4

ICU

DARNALL ARMY COMMUN
DEPARTMENT OF PA
FH MDA FORM 8 1

CHART COP

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

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

REPORTED BY (b)(6)-2

MD TECH

DATE 22 Oct 03

LAB ID NO.

MISC

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

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

SPECIMEN SOURCE (Specify) Blood

SPECIMEN/LAB RPT. NO

PATIENT'S MED. RECORD

557-107

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

REMARKS

CBC, BMP (b)(6)(2) 0440 HR

TEST(S)
SPECIMEN TAKEN
DATE 22 Oct 03 TIME 0415 A.M. P.M.
REQUESTED

RESULTS

WBC 5.1
RBC 2.67
Hgb 9.1
Hct 25.9
MCV 102
MCH 36.5
MCHC 35.2
Plt 214
L 44%
L #

TEST(S)
SPECIMEN TAKEN
DATE 23 Oct 03 TIME 0500 A.M. P.M.
REQUESTED

RESULTS

Glu -117
BUN-12
CRE-1.0
CK-618
K-3.6
Cl-99
tCO2-24
Ca-7.9*
Na-136

BMP, metabolyte 8

REMARKS (b)(6)-2

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY (b)(6)-2
MD DATE 23 Oct 03

Potus

(b)(6)-4

ICU

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

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
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PATIENT'S MED. RECORD

TEST(S)
SPECIMEN TAKEN
DATE 23 Oct 03 TIME 0500 A.M. ~~23 Oct 03 P.M.~~
REQUESTED

RESULTS

WBC-5.5
RBC-2.49
Hgb-8.4
Hct-22.6
MCV-90.8
MCH-33.9
MCHC-37.3
Plt-219
Ly%-14.3
Ly#-0.8

CBC

REMARKS (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 23 Oct 03

Potus

(b)(6)-4

ICU

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

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

PATIENT'S MED. RECORD

POTUS #

ECU

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2

REPORTED BY (b)(6)-2

REMARKS: MET 8 C̄ BMP

MD (b)(6)-2 DATE 24Oct03

ECH 0510hrs

PATIENT STATUS: BED ☒ AMB ☐ OUTPATIENT ☐ DOM ☐

SPECIMEN SOURCE: BLOOD ☒ OTHER (Specify) ☐ NP ☐

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

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

CHEM 1

TEST(S) SPECIMEN TAKEN			
DATE 24Oct03	TIME 0442 A.M. P.M.		
RESULTS	REQUESTED	(X)	
112	GLUCOSE		
11	UREA N.		
0.7	CREATININE	X	
	URIC ACID		
13	SODIUM		
4.0	POTASSIUM		
98	CHLORIDE		
22	CO_2		
NA	PHOSPHATE	X	
8.1	CALCIUM		
	TOTAL PROTEIN		
	ALBUMIN		
	GLOBULIN		
	ALKALINE PHOSPHATASE		
	ACID PHOSPHATASE		
	SGOT		
	LDH		
	CPK		
	BILIRUBIN (TOTAL)		
	BILIRUBIN (DIRECT)		
	CHOLESTEROL		
	TRIGLYCERIDES		
	AMYLASE		
	LIPASE		
	PROFILE (Specify)		
NA	Mg	X	

CHEMISTRY I
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
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PATIENT'S MED. RECORD

Enter in above space — PATIENT IDENTIFICATION—TREATING FACILITY—WARD

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2

REPORTED BY (b)(6)-2

REMARKS: CBC

MD (b)(6)-2 DATE 24Oct03

ECH 0510hrs

PATIENT STATUS: BED ☒ AMB ☐ OUTPATIENT ☐ DOM ☐

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

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

TEST(S) SPECIMEN TAKEN			
DATE 24Oct03	TIME 0442 A.M. P.M.		
RESULTS	REQUESTED	(X)	
2.79	RBC COUNT		
9.3	HEMOGLOBIN		
26.9	HEMATOCRIT		
96.0	MCV		
33.2	MCH		
34.6	MCHC		
6.3	WBC COUNT		
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE		
	NEUTRO-BANDS		
	NEUTROSEGS		
22.7%	LYMPHS %		
	EOSINOPHILS		
	BASOPHILS		
	MONOCYTES		
328	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		
1.4	INR		

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

PATIENT'S MED. RECORD

21st COMBAT SUPPORT HOSPITAL

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.	UNIT	DOB	RANK	SSN
Potus (b)(6)-4				

Physician:	Ward:	STAT / Routine	Specimen Date and Time:	Reported by:	Date and Time:
(b)(6)-2	ICU			(b)(6)-2 1745	25Oct03

Chemistry (i-STAT)

6+	7+	8+	Glu	Crea

Chemistry (Piccolo Analyzer)

Chem 12	MetLyte8	BMP	Liver

Hematology

CBC	Malaria	H/H

X	TEST(S)		
	SPECIMEN TAKEN		
	DATE 25 Oct 03	TIME 1520 A.M. P.M.	
	RESULTS	REQUESTED	(X)
	2.90	RBC COUNT	
	8.8	HEMOGLOBIN	
	26.0	HEMATOCRIT	
	89.5	MCV	
	30.5	MCH	
	34.1	MCHC	
	7.9	WBC COUNT	
		WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
		NEUTRO-BANDS	
		NEUTROSEGS	
		LYMPHS	
		EOSINOPHILS	
		BASOPHILS	
		MONOCYTES	
		PLATELETS	
		RBC	
		SED. RATE	
	394	PLATELET COUNT	
		RETICULOCYTE COUNT	
		CLOTTING TIME	
		BLEEDING TIME	
		PT CONTROL	
		PT PATIENT	
		PTT CONTROL	
		PTT PATIENT	
		PTT % ACTIVITY	
		PTT RATIO	
		SICKLING TEST	
	17.0	LE PREP	
	1.3	4.7	

REMARKS

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

TECH

MD DATE

LAB. ID. NO.

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

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

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

SPECIMEN/LAB RPT. NO.

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

CBC 25Oct03 1545

PHYSICIAN COPY

			REF. RANGE
			3.3-5.5 g/dL
			26-84 U/L
			10-47 U/L
			14-97 U/L
			11-38 U/L
			0.2-1.6 mg/dL
			7-22 mg/dL
			8.0-10.3 mg/dL
			100-200 mg/dL
			30-170 U/L
			98-108 mmol/L
			18-33 mmol/L
			0.6-1.2 mg/dL
			5-65 U/L
			73-118 mg/dL
			3.3-4.7 mmol/L
			6.4-8.1 g/dL
			128-145 mmol/L
			emistry
			Negative
			Negative
			Negative
			Negative
			Negative
			< 4.3 ng/mL
			< 0.19 ng/mL
			< 107 ng/mL
			iology

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		35.0-60.0%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		15.0-55.0%
	LY#		0.7-4.3 x10(3)/uL
	Differential		
	Segs 38		Mono 9
	Bands 19		Eos 5
	Lymph 29		Baso
	Atyp Ly		Immature cells
	RBC Morph:		
	Plt verify:		
	Spun Crit		35-60%
	Malaria Smear		
	Thin		No Plasmodium See
	Thick		No Plasmodium See
	Sed Rate		
	Sed Rate		1hr = 0-20 mm
	Coagulation		
	PT		10-13 seconds
	APTT		22.1-33.7 seconds
	FDP		Negative
	D-Dimer		Negative
	Fibrinogen		200-400 mg/dL
	Blood Bank		
	ABO/Rh		
	T&C		
	T&S		

Nitrite		Negative	FecLeuk		Negative
Leuko		Negative	Gram Stain		
Urine Microscopic			WetPrep		Negative
WBC		Epi	KOH		No Fungal Elements
RBC		Mucus	OccBld		Negative
Bacteria		Yeast	O&P		No Ova/Parasite
Casts:		Spermatozoa	HCG		
Crystals:		Amorph Sed	Urine		Negative
Other:			Serum		Negative
Other:					

TEST(S)

SPECIMEN TAKEN

DATE 25 Oct 03 TIME 0430 A.M. P.M.

RESULTS	REQUESTED	(X)
3.02	RBC COUNT	
9.3	HEMOGLOBIN	
26.9	HEMATOCRIT	
89.2	MCV	
30.9	MCH	
34.6	MCHC	
7.5	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
25.9	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
369	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	PT % ACTIVITY	
	PT RATIO	
	SICKLING TEST	
	LE PREP	
22	L/H	

REMARKS CBC

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

REQUESTING PHYSICIAN'S SIGNATURE Dr L (b)(6)-2

REPORTED BY (b)(6)-2

TECH MD DATE 25 Oct 03 0520 HR

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

HEMATOLOGY URGENCY ☐ ROUTINE ☒ BED ☐ AMB ☐ TODAY ☐ OUTPATIENT ☐ ☐ PRE-OP ☐ NP ☐ DOM STAT ☒ SPECIMEN SOURCE ☐ VEIN ☐ CAP ☐ OTHER (Specify)

HEMATOLOGY 549-107

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

Potus # (b)(6)-4 ICU

TEST(S)

SPECIMEN TAKEN

DATE 25 Oct 03 TIME 1550 A.M. P.M.

RESULTS	REQUESTED	(X)
	ROUTINE	
yellow	COLOR Clear	
1.010	SPECIFIC GRAVITY	
Neg	UROBILINOGEN	
trace	OCCULT BLOOD	
Neg	BILE	
Neg	KETONES	
Neg	GLUCOSE	
Neg	PROTEIN	
7.5	pH	
	MICROSCOPIC	
0-2	WBC	
0-5	RBC	
	EPITH CELLS	
	CASTS: WBC	
	CASTS: RBC	
	CASTS: HYALINE	
	CASTS: GRANULAR	
light	BACTERIA	
	CRYSTALS	
light	MUCUS	
Neg	NITRITE	
Neg	hem	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

REMARKS UA

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

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

REPORTED BY (b)(6)-2

TECH MD DATE 25 Oct 1605

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENTS MED. RECORD

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

URINALYSIS 550-107

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

Potus (b)(6)-4 ICU

Potus # (b)(6)-4 ICU

CHEM 1

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

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

SPECIMEN SOURCE ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

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

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

REPORTED BY (b)(6)-2

MD TECH DATE 25 Oct 03 0520 HR

LAB. ID. NO.

REMARKS Met 8, ~~Mg~~, ~~Ph~~, BMP

546-106

TEST(S)	TIME 0430 A.M. P.M. (X)	REQUESTED	RESULTS
		GLUCOSE	99
		UREA N.	9
		CREATININE	1.1
		URIC ACID	
		SODIUM	133
		POTASSIUM	3.7
		CHLORIDE	98
		CO_2	23
		PHOSPHATE	
		CALCIUM	8.2
		TOTAL PROTEIN	
		ALBUMIN	
		GLOBULIN	
		ALKALINE PHOSPHATASE	
		ACID PHOSPHATASE	
		SGOT	
		LDH	
		CPK	190
		BILIRUBIN (TOTAL)	
		BILIRUBIN (DIRECT)	
		CHOLESTEROL	
		TRIGLYCERIDES	
		AMYLASE	
		LIPASE	
		PROFILE (Specify)	

DATE 25 Oct 03

CHEMISTRY 1

STANDARD FORM 546 (Rev. 8-71) General Services Administration and Interagency Committee on Medical Records FIRMR (41 CFR) 101-11.606-4

Potus

FCU

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REMARKS (b)(6)-2

REPORTED BY

TECH ID DATE

26 Oct 03 0450 HR

CHEM I

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

PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ DOM

SPECIMEN SOURCE: ☐ NP ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

Pt refuses not taking meds

(b)(6)-4

(b)(6)-2

Pt refuses not taking meds

TEST(S)		
SPECIMEN TAKEN		
DATE 26 Oct 03	TIME 0410	A.M. P.M.
RESULTS	REQUESTED	(X)
116	GLUCOSE	
9	UREA N.	
0.7	CREATININE	
	URIC ACID	
131	SODIUM	
3.5	POTASSIUM	
97	CHLORIDE	
24	CO_2	
	PHOSPHATE	
8.2	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

CHEMISTRY I

STANDARD 546 (Rev. 8-77)
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FIRMR (41 CFR) 201-45.505

546-107

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REMARKS CBC

Dr. (b)(6)-2

REPORTED BY

TECH MD DATE

26 Oct 03 0450 HR

HEMATOLOGY

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

PATIENT STATUS: ☒ BED ☐ AMB ☐ OUTPATIENT ☐ DOM

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

LAB. ID. NO.

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

(b)(6)-4

(b)(6)-2

TEST(S)		
SPECIMEN TAKEN		
DATE 26 Oct 03	TIME 0410	A.M. P.M.
RESULTS	REQUESTED	(X)
2.97	RBC COUNT	
9.0	HEMOGLOBIN	
26.9	HEMATOCRIT	
90.6	MCV	
30.2	MCH	
33.3	MCHC	
9.4	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
12.4%	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
465	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTHROMBIN CONTROL	
	PROTHROMBIN PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE-PREP	
1.2	Hct	

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-79)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

549-107

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES

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

TEST(S): CBC

SPECIMEN TAKEN: DATE 27 Oct; TIME 0500 A.M. / P.M.

RESULTS	REQUESTED	(X)
3.05	RBC COUNT	
9.5	HEMOGLOBIN	
27.5	HEMATOCRIT	
91.0	MCV	
31.0	MCH	
34.1	MCHC	
9.9	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
20.2%	LYMPHS 20.1%	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
642	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT: CONTROL	
	PTT: PATIENT	
	PROTHROMBIN TIME: CONTROL	
	PROTHROMBIN TIME: PATIENT	
	PROTHROMBIN TIME: % ACTIVITY	
	PROTHROMBIN TIME: RATIO	
	SICKLING TEST	
	LE PREP	
20	L of H	

REMARKS: CBC

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

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

REPORTED BY: (b)(6)-2

TECH: (b)(6)-2 MD: (b)(6)-2 DATE: 270ct03 0500 HR

LAB. ID. NO.

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

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

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

CHEM I URGENCY: ☐ ROUTINE ☐ TODAY ☐

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

Potus (b)(6)-4 ICU

CHEMISTRY I — STANDARD FORM 546 (Rev 8-77) PRESCRIBED BY GSA ICMR FIRMR (41 CFR) 201-45.505 — 546-107

TEST(S): BMP

SPECIMEN TAKEN: DATE 27 Oct; TIME 0500 A.M. / P.M.

RESULTS	REQUESTED	(X)
95	GLUCOSE	
8	UREA N.	
1.0	CREATININE	
	URIC ACID	
136	SODIUM	
4.1	POTASSIUM	
97	CHLORIDE	
25	CO_2	
	PHOSPHATE	
8.5	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS: BMP

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

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

REPORTED BY: (b)(6)-2

TECH: (b)(6)-2 MD: (b)(6)-2 DATE: 270ct03 0500 HR

LAB. ID. NO.

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

PRE-OP STAT ☐

Potus (b)(6)-4 ICU

PATIENT'S ME

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

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)											
Versed	(mg)	1										
Fentanyl	(mg)	100		100	100			100			100	
Propofol	(mg)	100										
Sch/Vec	(mg)	80	5	3		2		2	2		1	
	( )											
	( )											
VOLAT AGENT: Forane	% del / % e.t.	1.2	1.5	2	2	1.5	1.5	1.5	1.5	1.5	1.5	1.5
AIR	L/Min											
N2O	L/Min								.5		.5	.5
O2	L/Min	6	2	1	1	1	1	1	1	.5	.5	.5

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

FLUIDS

LINE site											
Rt L AC	☐ Warmed	LR#1									
Rt g R	☐ Warmed			LR#2	LR#3		LR#4	LR#5			
	☐ Warmed										
	☐ Warmed										

LOSSES

EST BLOOD LOSS											
URINE - Foley						50	—	—		75/125	

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

1730 Urasyn 3GM IV PB

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

BODY WEIGHT: ~135 KG (LB)

HEMATOCRIT: 32.4

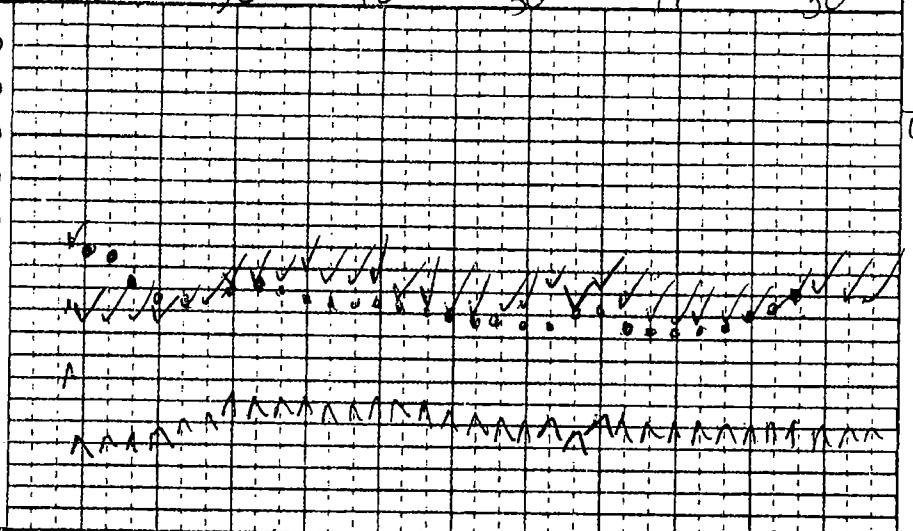
INITIAL DATA: BP- 130/80 HR- 102

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1700

TIME → 1700 30 1800 30 1900 30

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



VENTIL

VT - ml			650	640	700	660	690	690	720	700	740	710
f - breaths/min			10	10	10	8	8	8	8	8	8	8
Peak inf pres / PEEP			22	24	25	25	25	25	25	25	25	25
MODE - S(pon), A(sist), C(on)		SV CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	33	33	31	33	33	32	33	34	37	33
BP/oth	FIO2 (Frac or %)	1	0.78	0.79	0.79	0.81	0.80	0.80	0.79	0.66	0.50	0.51
ART line	SpO2 (%)	100	100	100	99	99	99	99	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	SB	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Skin		37.5	37.5	38	37.5	38	38	37.5	37.5	37.5	37.5
	M-M Block (T/4)		4/4		0/		1/	2/	4			
Warming blkt												
Conv warmer												

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

RECOVERY AT 2250

PACU ICU #1 (Specify)

OTHER SV Fio2 0.60

CONDITION: 99.6

RESP- SpO2-

BP- 137/89 HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1650	1700	2250
	Ready	Begin	End
PROC	1708	1714	2245

PROCEDURES and CPT Codes: Cr Lap, Appy, Entrolysis, Repair

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

Pvt Mo F (b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA EGTT

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

Difficult Laryngoscopy thick mucus + dried blood, cricoid views 7.5 ETT + Stylet DRS + ETCO2

SURGEONS: Dr (b)(6)-2

PROCEDURE LOCATION: OR #1

DATE: 10/19/03

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Explap-	~20	~135	

PHYSICAL STATUS: 1 (2) 3 4 5 6 7 E

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER 11.4 / 32.4	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) Unknown	BP 124/77 PULSE 109 ECG (IF PERTINENT) 101.3 Unknown	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) Unknown	(ALLERGIES) Unknown Unknown

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS
Unknown.	Unknown.

PREOPERATIVE DIAGNOSIS	PREMEDICATION
	(b)(6)-2 [redacted]

DATE 10/19/03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

10 OCT 03 / 0745 Chart review completed. Transfused 2U PRBCs ≈ 0045 2° ↑ HR ~140's. H&H prior 11.3/34.4. No apparent anesthetic sequela. VSS remain stable this AM. [redacted] (b)(6)-2 [redacted] CPT, CANNS

(b)(6)-4 [redacted]

*U.S. Government Printing Office: 1994 — 300-892/10029

MEDICAL RECORD - ANESTHI

ıse of this form, see AR 40-66; the proponent a , the OTSG

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

DRUG	(Units)												
VQ3	(mg)	1											
	( )												
Morphine	(mg)					3							
	( )												
	( )												
	( )												
VOLAT AGENT Forane	% del	1	1	.5 X									
	% e.t.												
AIR	L/Min	.5	.5	X									
N2O	L/Min												
O2	L/Min	.5	.5	6 →									

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

FLUIDS

LINE site													
18G L AC	☐ Warmed	3000											
16g R	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS													
URINE -	125/250												

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: ~135 KG (LB)

HEMATOCRIT: 32.4

INITIAL DATA: BP- 130/80 HR- 102

EQUIP CHECK OK? Y N

PATIENT OK for PROCEDURE? TIME-

TIME → 1945 20 30 21

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

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

VENTIL

VT - ml	730	730	830			
f - breaths/min	8	8	8			
Peak inf pres / PEEP	25	25	26			
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	SV →		

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	34	35	29	40	45	
BP/oth	FIO2 (Frac or %)	.51	.52	.71	.80 →		
ART line	SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	ECG	ST	ST	ST			
Gas analyzer	TEMP-site Kr	36.5	37	37			
	N-M Block (T/4)				4/4		
Warming blkt							
Conv warmer							

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

TOTALS

TOTAL EBL	TOTAL URINE
200	250

FLUIDS - SUMMARY

CRYSTALLOID- 3000

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

2025 Neostigmine 3mg Robinul 0.6mg

2248 SV/CC
(+) flex/ext all extremities
(+) head lift x 5 sec
Extubated @ Suctioning oral pharynx.
TOBCW SV.

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Explap

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

Pulmo (b)(6)-4

(b)(6)-2

(b)(6)-2

PROCEDURE

DATE: 9/8/19/03

PAGE 2 OF 2

DA FORM 7389, FEB 1998 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 2491

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*: 1 Unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 19 OCT 03

DATE AND HOUR REQUIRED: 19 OCT 03 2350

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

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: S/p Schrapnel wounds s/p Ex lap

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

SIGNATURE OF VERIFIER: (b)(6)-2 Error of omission, spec, 916242

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO O; Rh NEG

RECIPIENT: ABO O; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
not performed	comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

(b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 20 Oct 03

REMARKS: Due to the critical condition of the below named patient, the requesting physician named above is requesting immediate release of this blood product w/out complete testing and is accepting full responsibility of the administration of this transfusion.

SECTION III – RECORD OF TRANSFUSION

(b)(6)-2

AT (Hour) 0030 ON (Date) 20 October 2003

IDENTIFICATION

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

(b)(6)-2 Got AN

(b)(6)-2 spec, 91 with 2

PRE-TRANSFUSION

TEMP. 98.8 PULSE 120 BP 147/72

DATE OF TRANSFUSION: 20 OCT 03

TIME STARTED: 0045

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 Unit ML

TIME/DATE (COMPLETED) INTERRUPTED: 0145 20 Oct 03

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE: 99.1

PULSE: 120

BLOOD PRESSURE: 138/42

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)-2 Got AN

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

Name/Rank: Potus

SSN #:

DOB:

Unit:

(b)(6)-4

Male

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 2492

Medical Record Copy

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER 10/19/03 TIME OF ORDER 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICU s/p scrotal wounds
? LOC (b)(6)-2
(2) Condition stable
(3) Vital q 2°
(4) Neuro q 1°
(5) Activity Bed rest

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(6) IV: D5 1/2 NS @ 100 cc/hr
(7) Ancef 1 gram IVPB q 8°
(8) HOB @ 30 degrees
(9) Diet NPO
(10) CBC, BMP in AM

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 10/19/03 TIME OF ORDER 1445 HOURS

(1) CBC @ 1500

(b)(6)-2

1530 HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Potus (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 Oct 03 TIME OF ORDER: 2100 ~~HOURS~~

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU
2. Dx: s/p Repair of Small & Lg Bowel Injury
3. Vitals: q 1°, I&O's
5. Act: Up to Chair q Shift beginning 20 Oct
6. Diet: NPO
7. O2 - Wean to Maint O2 Sat > 93%

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

8. Foley to Gravity
9. NG to Low Int Suction
10. IV: LR at 150cc/hr
11. Unasyn 3.0gm IVPB q 6°
12. Zantac 50mg IVPB q 8°
13. Morphine 2-8mg IVP q 1-2° prn
14. Phenergan 12.5mg IVP q 4° prn Nausea
15. If Able - Incentive Spir q 1° WA

noted 19 Oct 2145 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

16. CBC, Chem-7 q am (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 Oct 03 TIME OF ORDER: 2300 HOURS

1. Bolus 1 Liter LR Done (b)(6)-2

noted 19 Oct 03 2305 (b)(6)-2 Got it

DA FORM 1 APR 79 4256 REPLACE MEDCOM - 2494 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

Potus (b)(6)-4

DATE OF ORDER: 19 Oct 03 TIME OF ORDER: 2350 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) CBC NOW Done

(2) Transfuse 2 Units PRBC call over 1 hour

Noted 20 Oct 03 0030

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 20 Oct 03 TIME OF ORDER: 0920 HOURS

(1) Nutrition Consult

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 20 Oct 03 TIME OF ORDER: 1045 HOURS

(1) Met Lytes / BMP

(2) Change IV to Ds ½ NS c̄ 20 meq KCl/l at 125 cc/hr

Noted 10/20/03 1135

(b)(6)-2

NURSING UNIT | ROOM NO. | NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 20 Oct 03 TIME OF ORDER: 1241 HOURS

(1) Change A.M. Labs to CBC & BMP

(2) Change IV to Ds NS c̄ 20 meq KCl/l at 125 cc/hr

(3) ↓ Vitals to q 4°

(4) Tylenol 650 mg PR q 6° prn Temp > 101°

Noted 10/20/03 1353

(b)(6)-2

NURSING UNIT | ROOM NO. | NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

POTUS # (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 OCT 03 TIME OF ORDER: 1700 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Tube feedings c̄ osmalite HN 20cc/h, advance by 10cc/h q 6h as tolerated until target rate of 80cc/h when bowel fn
2. daily Met-6 panel c̄ Mg+ & PO4 (qAM)

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 OCT 03 TIME OF ORDER: 1740 HOURS

1. Ensure can be substituted if osmalite HN not available

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 OCT 03 TIME OF ORDER: 2103 HOURS

1. Hold Tube feeds for now
2. Cont NG to LIS

(b)(6)-2

2103 20 OCT 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 OCT 03 TIME OF ORDER: 1000 HOURS

1. ice chips as tolerated (80 q shift)
2. ↓ IV rate to 75cc/h D5 NS c̄ 20 mEQ
3. encourage ambulation

(b)(6)-2

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

POTUS# (b)(6)-4

DATE OF ORDER: 21 Oct 03 TIME OF ORDER: 2017 HOURS

LIST TIME ORDER NOTED AND SIGN

1. PCXR

(b)(6)-2

21 Oct 03 2018 (b)(6)-2 done 2030

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 22 Oct 03 TIME OF ORDER: 1024 HOURS

1. N-T Suction q 4°
2. ↑ Maint IV to 100cc/hr.
3. UA to Lab
4. d/c Unasyn
5. Primaxin 500mg IV q 6°

(b)(6)-2

NOTED 1UT MR 10/22/03 1025

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

PATIENT IDENTIFICATION

DATE OF ORDER: 22 Oct 03 TIME: 1219 HOURS

1. d/c NG - done
2. d/c Foley done 1200hrs.
3. Due to Void by 2000

(b)(6)-2

noted 22 Oct 03 1250

NURSING UNIT | ROOM NO. | NO. (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 22 Oct 03 TIME OF ORDER: 2000 HOURS

1. clear liquids as tolerated

(b)(6)-2

noted 22 Oct 03 2005

NURSING UNIT | ROOM NO. | BED NO.

24° Chart ✓ (b)(6)-2 copy 23 Oct 0001

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Potus # [redacted]

DATE OF ORDER: 22 Oct 03 TIME OF ORDER: 2051 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Mucomyst / Albuterol Nebs q 4°

[redacted]

noted 22 Oct 03 2100 [redacted]

NURSING UNIT: ICU ROOM NO.: BED NO.:

24° Chart ✓ [redacted] 22 Oct 03 @ 2355

PATIENT IDENTIFICATION

POTUS # [redacted]

DATE OF ORDER: 23 Oct 03 TIME OF ORDER: 0251 HOURS

1. Dulcolax Supp PR Now and Repeat in 3°
2. d/c Tylenol Suppository
3. Tylenol 650mg po q 4° prn Temp > 101°
4. NPO ∓ Meds.

noted 23 Oct [redacted]

[redacted]

NURSING UNIT: ICU ROOM NO.: BED NO.:

PATIENT IDENTIFICATION

POTUS # [redacted]

DATE OF ORDER: 24 Oct 03 TIME OF ORDER: 0900 HOURS

1. clear liquid diet as tolerated
2. ambulate ~~AT LEAST~~ Q.I.D.

noted 24 Oct 03 [redacted]

NURSING UNIT: ICU ROOM NO.: 2W0 BED NO.: Chart ✓ [redacted] 24 Oct 03 @ 2300

PATIENT IDENTIFICATION

POTUS # [redacted]

DATE OF ORDER: TIME OF ORDER: HOURS

NURSING UNIT: ICU ROOM NO.: BED NO.:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER: 24 Oct 03 TIME OF ORDER: 1418 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Decrease Albuterol Nebs to q Shift
2. ↓ Maint IV to 50cc/hr

noted 24 Oct 03 1420

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER: 24 Oct 03 TIME OF ORDER: 1749 HOURS

1. Percocet 1-2 po q 4-6 prn

24 Oct 1749

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Potus # (b)(6)-4

DATE OF ORDER: 24 Oct 03 TIME OF ORDER: 2012 HOURS

1. Change Percocet to 1 po q 4° prn
2. d/c Morphine
3. CXR PA & Lat

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° Chart ✓ Ambulate cpap/no 24 Oct 03 2300

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Oct 03 TIME OF ORDER: 2330 HOURS

1. d/c NT Suction

(b)(6)-2

noted (b)(6)-2 24 Oct 03 @ 2330

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: Potus # (b)(6)-2

DATE OF ORDER: 25 Oct 03 TIME OF ORDER: 0945 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ↑ diet to soft
2. ↑ diet as tolerated for dinner to regular
3. d/c Primaxin
4. Levaquin 500mg po bid

(b)(6)-2

25 Oct 03 1410 MJ

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: Potus # (b)(6)-2

DATE OF ORDER: 25 Oct 03 TIME OF ORDER: 1516 HOURS

1. CBC, UA Stat
2. d/c Zantac
3. d/c Levaquin

(b)(6)-2

25 Oct 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: Potus # (b)(6)-2

DATE OF ORDER: 25 Oct 03 TIME OF ORDER: 1634 HOURS

1. Levaquin 500mg po bid

(b)(6)-2

25 Oct 03 1640 MJ

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ completed (b)(6)-2 CPT 25 Oct 03 @ 2330

PATIENT IDENTIFICATION: Potus # (b)(6)-2

DATE OF ORDER: 26 Oct 03 TIME OF ORDER: 1049 HOURS

1. Hep-Lock IV
2. Zantac 150mg po bid
3. Dulcolax Supp PR ✓ x 1 this a.m.
4. PA + Lat CXR

(b)(6)-2

Note 10/26/03

NURSING UNIT | ROOM | NO.

DA FORM 1 APR 79 4256 (b)(6)-2 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: Potus (b)(6)-4

DATE OF ORDER: 26 Oct 03 TIME OF ORDER: 1330 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Valace 100mg po bid (b)(6)-2

NURSING UNIT: clast ✓ ROOM NO.: 27oct03 (b)(6)-2

Pt Stable 10/27/03 1330

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 27 Oct 03 TIME OF ORDER: 0930 HOURS

1. Ambien 10mg qhs prn insomnia
2. ensure, 1 container b/w meals at least 1x/day (b)(6)-2

NURSING UNIT: ROOM NO.: (b)(6)-2

Pt Stable 10/27/03 0930

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 27 Oct 03 TIME OF ORDER: 1030 HOURS

1. d/c Daily CBC, RUP
2. d/c Hep-Lock (b)(6)-2

NURSING UNIT: ROOM NO.: BED NO.:

PATIENT IDENTIFICATION: Potus (b)(6)-4

DATE OF ORDER: 27 Oct 03 TIME OF ORDER: 1200 HOURS

1. d/c to MP's Custody (b)(6)-2

done 1230 (b)(6)-2

NURSING UNIT: ROOM NO.: BED NO.:

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

CLINICAL RECORD

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

Mo. OCT Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22
19 Oct	(b)(6)-2	VS: q 2°	D	(b)(6)-2			
			E				
			N				
19 Oct		Neuro ✓ q 1°	D	(b)(6)-2			
			E				
			N				
19 Oct		Activity: Bed Rest	D	(b)(6)-2			
			E				
			N				
19 Oct		HOB @ 30 degrees	D	(b)(6)-2			
			E				
			N				
19 Oct		Diet: NPO	D	(b)(6)-2			
			E				
			N				

Pt Expired

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p scrapnel wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS # (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

MEDCOM - 2502

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
19Oct	(b)(6)-2	Admit to ICU; S/p scrapped wounds; Dr Eastman	19 Oct	now	1050	(b)(6)-2
19Oct		Condition: Stable	19 Oct	now	1050	
19Oct		CBC, BMP in AM	20 Oct	0500		
19Oct		CBC @ 1500	19Oct	1500		(b)(6)-2

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

★ U.S. GPO:1997-418-290/55257

MAR

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.	MoAUT Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22
19 Oct	(b)(6)-2	IV D5 ½ NS @ 100cc/hr	D	(b)(6)-2			
			E				
			N				
19 Oct	(b)(6)-2	Ancef 1G IVPB 98	03			D/C to Surgery	
			11	(b)(6)-2			
			19				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P scrapnal wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS # (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

MEDCOM - 2504

MAR

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. Oct Yr. 03

TEMPT BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27
19OCT03	(b)(6)-2	O_2 - wean to maintain	D	✓	(b)(6)-2							
		Sats >93%	E	✓								
			N	(b)(6)-2								
19OCT03	(b)(6)-2	IV - LR @ 150cc/hr	D	✓	(b)(6)-2							
			E	✓								
			N	(b)(6)-2								
19OCT03	(b)(6)-2	Unasyn 3.0gm IVPB	05	✓	(b)(6)-2							
		q6°	11	✓								
			17	(b)(6)-2								
			23									
19OCT03	(b)(6)-2	Zantac 50mg IVPB	08	✓	(b)(6)-2							
		q8°	16	✓								
			24	(b)(6)-2								
20OCT03	(b)(6)-2	D5½NS c̄ 20meq Kcl	D	✓								
		@125cc/h	E	✓								
			N	✓								
20OCT03	(b)(6)-2	D5NSc̄ 20meq/Kcl	D	✓	(b)(6)-2							
		@ 125cc/h	E	✓								
21OCT	(b)(6)-2	↓ D5NSc̄ 20Kcl to Fch	N	✓								
20Oct03	(b)(6)-2	Tube Feeding c̄ Osmolite HN	D	✓								
		20cc/° ↑ by 10cc/° q6° as	E	✓								
		tolerated until target rate	N	✓								
		of 80cc/° When bowel										
		Sound return. May sub										
		c̄ Ensure if no Osmolite										
20OCT03	(b)(6)-2	Hold Tube feeds for now			(b)(6)-2							

ALLERGIES: ☐ YES ☒ NO — NKA

PRIMARY DIAGNOSIS: S/P Repair of small + lg bowel injury

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO: 3

PATIENT IDENTIFICATION: Pohes (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

MEDCOM - 2505

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	
19 Oct	(b)(6)-2	Bolus 1L LR	19 Oct	NOW	1305		(b)(6)-2
20 Oct	(b)(6)-2	Give 2 units PRBC's #1	20 Oct	ASAP	0045		
		#2	20 Oct	ASAP			
20 OCT	(b)(6)-2	Continue NG to LIS and hold tube	20 OCT	NOW			
		feeds for now					
23 Oct	(b)(6)-2	Dulcolax supp PR now + repeat in 30	23 Oct	1000	done		
			23 Oct	1300	1320		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
19 OCT	(b)(6)-2	Morphine 2-8mg WP q 1-2° prn	4mg 2215	4mg 2230	2mg IV 0000	10/30 1100	10/30 1300	10/30 1805	10/21 0400	10/21 0200	10/21 0620	10/21 1015	10/21 1040	10/21 1645	10/21 1845	10/21 2100
			19 Oct	19 Oct	20 Oct	10mg IV	4mg IV	3mg	3mg	4mg	3mg IV	3mg IV	4mg	4mg	4mg	4mg
19 OCT	(b)(6)-2	Phenergan 12.5mg IVP q 4° PRN nausea														
20 OCT 03	(b)(6)-2	TYLENOL 650mg PR	10/20 1255	10/21 1850	10/22 0700	10/22 2000										
		Q6° prn Temp > 101°	TW	TPR	TPR	PR										
19 OCT	(b)(6)-2	Morphine 2-8mg IVP	10/22 0245	10/22 0715	10/22 1625	10/23 0230	23 Oct 0700	23 Oct 3mg	OCT 2308							
		Q 1-2° prn	4mg	4mg	3mg	2mg	4mg	3mg	2mg							
23 Oct	(b)(6)-2	Tylenol 650mg po	10/23 1700	10/25 1530	10/26 2310											
		q4° prn T>101														

(b)(6)-2

D/C 23 Oct 03

D/C'd 24 Oct 03

(b)(6)-2

★ U.S. GPO:1997-418-290/55267

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.

No. OCPY. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27
19OCT03	b(6)-2	Vitals q1°, I+Os	D	/	b(6)-2							
			E	/								
			N	(b)(6)-								
19OCT03	b(6)-2	Activity - up to chair	D	/	b(6)-2							
		q shift beginning 20 OCT	E	/								
		Amulate at least QID	N	/								
19OCT03	b(6)-2	Diet: NPO ε sips	D	/	b(6)-2							
			E	/	b(6)-2							
			N	(b)(6)-2								
19OCT03	b(6)-2	Foley to gravity	D	/								
			E	/								
			N	(b)(6)-2	b(6)-2							
19OCT03	b(6)-2	NG to low int	D	/								
		Suction	E	/								
			N	(b)(6)-2								
19OCT03	b(6)-2	If able - incentive	D	/	b(6)-2							
		spir q1° WA	E	/								
			N	(b)(6)-2								
19OCT03	b(6)-2	CBC, chem 7 q AM	05	/								
20OCT03	b(6)-2	CBC & BMP QAM	05	/								
19OCT03	b(6)-2	I&O Q1°	D	/	b(6)-2							
			E	/								
			N	/								
20OCT03	b(6)-2	VITAL SIGNS Q4°	D	/								
			E	/								
			N	/								

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: s/p Repair of small + lg bowel injury

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

Potus 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 4077

MEDCOM - 2507

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo OCT Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 OCT03	(b)(6)-2	Admit to ICU	Noted			
20 OCT03		MET LYTES / BMP	10/20	now	1050	(b)(6)-2
21 Oct	(b)(6)-2	Portable CXR	21 Oct	now	2030	
22 Oct		Due to void by 2000 hrs	22 Oct	2000		
24 OCT03	(b)(6)-2	CXR Pa/lat	24 OCT	Now	2030	
25 Oct	(b)(6)-2	CBC, UA STAT	25 Oct	done	1545	
26 OCT		PA & LAT CXR	10/26	now	1105	

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

☆ U.S. GPO:1997-418-290/55267

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27
20Oct03	(b)(6)-2	Daily Met-6 panel &	05	(b)(6)-2						
		Mg i PO4 q AM								
10/21/03	(b)(6)-2	ICE CHIPS AS TOLERATED	D	(b)(6)-2						
		Q Shift	E	(b)(6)-2						
			N							
10/21/03	(b)(6)-2	ENCOURAGE AMBULATION	D	(b)(6)-2						
			E							
			N	(b)(6)-2						
10/22/03	(b)(6)-2	N-T SUCTION Q 4°	D	(b)(6)-2						
			E							
			N							
22OCT03	(b)(6)-2	Clear Liquids as	B	(b)(6)-2						
		tolerated	L							
			D	(b)(6)-2						
23oct	(b)(6)-2	NPO x meds	D	(b)(6)-2						
			E							
			N							
24oct03		clear liquid diet as	D	(b)(6)-2						
		tolerated	E							
			N							
24oct03		Ambulate at least	D	(b)(6)-2						
		Q.I.D	E							
			N							
25Oct	(b)(6)-2	↑ diet to soft, advance	B	(b)(6)-2						
		to regular as tolerated	L	(b)(6)-2						
			D							

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Repair of small & LRG bowel repair

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

POTUS (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

MEDCOM - 2509

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN-MEDICATION

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

10 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	MR	DATE COMPLETED 22	23	24	25	26	27
10/22/03	(b)(6)-2	D5NS ĉ 20 mcg	D	(b)(6)-2					
		KCl @ 100cc/hr	E				Did 24 Oct 03	(b)(6)-2	
			N						
10/22/03	(b)(6)-2	PRIMAXIN 500mg	06						
		IV @ 6°	12				25 Oct 03		
			18				1400	(b)(6)-2	
			24						
22 Oct 03	(b)(6)-2	Mucomyst/Albuterol	D						
		Nebs q 4°	E	(b)(6)-2				(b)(6)-2	
			N						
22 Oct 03		Mucomyst/Albuterol	02						
	(b)(6)-2	Nebs q 4°	06		(b)(6)-2				
			10				Did 24 Oct 03		
			14					(b)(6)-2	
			18						
			22						
24 Oct 03	(b)(6)-2	↓ Maint IV to 50 ml/hr	D			(b)(6)-2			
		D5NS ĉ 20 mEq KCl/L	E		(b)(6)-2			Did 10/26/03	(b)(6)-2
			N		(b)(6)-2	(b)(6)-2			
24 Oct 03	(b)(6)-2	Albuterol neb q	06						
		Shift	14			(b)(6)-2			
			22						
25 Oct 03	(b)(6)-2	Levaquin 500mg	06				Did 25 Oct 03		
		po BID	18			(b)(6)-2			
25 Oct 03	(b)(6)-2	Levaquin 500mg	06						
		po BID	18						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Repair of Small & Large Bowel Injury

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 4

PATIENT IDENTIFICATION: POTUS (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0	8	9	10	11	12	13	14	15
8	16	17	18	19	20	21	22	23
1	10	11	12	13	14	15	16	17

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo Oct Yr 03

Order Time	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24 Oct	(b)(6)-2	~~Percocet 1-2 po q4-6° prn~~				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED	
24Oct	(b)(6)-2	Percocet 1-2 po q 4-6° prn pain	24 OCT 1805 TM	Did 24 Oct 03 (b)(6)-2
24 Oct	(b)(6)-2	Percocet ÷ Q4° PRN	24Oct 2600 2210 0225 (b)(6)-2	

"M.A.R."

CLINICAL RECORD

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

Oct 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27
10/24/03	Recopied (b)(6)-2	ALBUTEROL NEBS q	06	/ (b)(6)-2	
	-----	Shift	14	(b)(6)-2	
	-----		22	(b)(6)	
10/24/03	Recopied (b)(6)-2	LEVIQUIN 500mg PO	06	/ (b)(6)-2	
	-----	BID	18	(b)(6)-2	
10/26/03	(b)(6)-2	ZANTAC 150mg PO	10	(b)(6)-2	
	-----	BID	22		
10/26/03	(b)(6)-2	HEPLOCK IV	D		
	-----	(Flush Q Shift c̄ NS)	E		
	-----		N		
26 Oct	-----	Colace 100mg po	06		
	(b)(6)-2	BID	18		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: SIP Repair small & Lab bowel

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 8 9 10 11 12 13 14 15

16 17 18 19 20 21 22 23

MEDCOM - 2512

Verify by initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo OCT Yr 2025

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/26	(b)(6)-2	DULCOLAX Supp. PR X 1 ~~[illegible]~~ this am	10/26	A.M.	1130	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION / TIME/DATE COMPLETED
10/19	Recupick (b)(6)-2	PHENERGAN 125 mg	
		IV Q 4° PRN NAUSEA	
10/23	Recupe (b)(6)-2	Tylenol 650 mg Po	
		Q 4° PRN T > 101	
10/24	(b)(6)-2	Percocet 1 PO Q4°	
		PRN	
10/27	(b)(6)-2	Ambien 10mg QHS	
		PRN INSOMNIA	

CLINICAL RECORD

THERAPEUTIC SUPPLEMENTATION CARE PLAN (NON-MEDICATION)

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 27	28	29
10/27	(b)(6)-2	ENSURE 1 CONTAINER	10			
		B/w MEALS AT LEAST	14			
		1X/day	18			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Repair SMI & CRC Bowel

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

POTUS (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

0 8 9 10 11 12 13 14 15

16 17 18 19 20 21 22 23

24 01 02 03 04 05 06 07

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: POST ANESTHESIA CARE UNIT FLOWSHEET

Unsyn 39m 1730, NGT

OTSG APPROVED (Date): 17 Jan 80

PROCEDURE: Exp lap, appy, enterotomy repair

PHYSICIAN: Dr [(b)(6)-2]

ANESTHESIA BY: MAJ [(b)(6)-2]

(Gen) Spinal MAC Axillary Local Bier Epidural Other

ALLERGIES: Unknown

AIRWAYS: Time DC'D

ETT (Nasal) Oral Trach

OXYGEN: (Mask) Nasal Prongs Face Tent Blow-By

Liter/min. %

ASA II History

Cardiac Rhythm

IV#1 LRCTKP Patent Infiltrated

Site R FA Rate Gauge 16

IV#2 LRC Patent Infiltrated

Site 16D Rate Gauge 18

DAC

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PARS	COMMENTS	Neuro-Vascular
PRE-OP	130/80	102											Exp: L R Upper Lower; Pulse DP PT RAC
PRE-OP	/												Blanche Warm Pulse Moves Y N
2100	137/81	117	18	100%	99.6	1	1	2	0	2	6		Blanche Warm Pulse Moves Y N
2105	141/76	114	16	100%		1	1	2	0	2	6		Blanche Warm Pulse Moves Y N
2110	149/78	113	16	100%		1	1	2	0	2	6		Blanche Warm Pulse Moves Y N
2125	170/77	115	18	100%		1	2	2	0	2	7		Blanche Warm Pulse Moves Y N
2140	147/77	119	19	100%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
2155	134/80	123	19	99%		1	2	2	1	2	8		Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N
	/												Blanche Warm Pulse Moves Y N

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

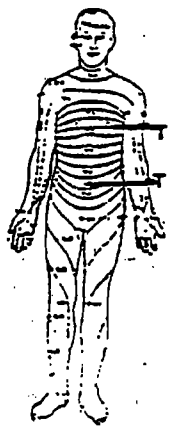
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respirations
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or jaw support
0—Needs ventilator; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP ~~20~~ - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 96°
1—Skin is pale, blotchy, dusky &/or temperature 95 - 96°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze		
Opsite		
Bandaid		
Steri-strips		
Collodian		
Peri-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES AND DRAINS: Hemovac Foley NGT Chest Jackson-Pratt

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 19OCT03

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

Pohs [(b)(6)-4]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FH MDA OP 132-11a (Rev) 1 Sep 99

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AMT
OR	UR	5000	OR	EBL	200
			OR	Urine	250
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to FH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

2115 - Midline incision covered c̄ fluffs and foam tape. Multiple areas c̄ bandaids on chest. Hand (R) wrapped in kulis all disp CDI. Lungs clear in upper lobes. Rhonchi to Bases (B). NGT placement verified now to LIS. Foley gravity draining dark yellow urine. [redacted] KN

2130 - O_2 Mask removed sats 100% on RA [redacted]

2205 - To Icu status. Remains unresponsive. (not to follow) [redacted] CPT AN

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	PAIN LEVEL	EFFECTIVENESS

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in wheelchair.
Dressing status: CDI PAR Score 8 Safety Straps 4
Report given to N/A Remains in ICU. Patient released by Anesthesia
Time out 2205. Nurse Signature: [redacted] CPT AN

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION

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
		1020	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 6	0 9 3 3 4

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	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y Y Y M M D D)
0 5		2 0 3 1 0 2 7

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

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)
	A 1 9 A 1	2 0 0 3 1 0 1 9

FOR LOCAL USE

Dx: 86354
86331
86397
8831
8738
E9719
2768
490
9584
9110
5180
88000
7806

Px: 4562
4675
4671
8365
4719
5794
966
4502
4503
4602
8622 X3

TRAUMA
9

INJURY
559

(b)(6)-2

SIGNATURE OF ADMITTING CLERK

MEDCOM - 2517

(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 (F...

(b)(6)-4

(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)-4

(b)(6)-4

(b)(6)-2

25. TYPE DISPOSITION

DIC

...OSITION

5 NOV 03

31. SELECTED ADMINISTRATIVE DATA

...TS OF WHOLE BLOOD/COMPONENT TRANSFUSED

33. CAUSE OF INJURY

Gunshot wound

☐ CHECK IF CONTINUED ON REVERSE

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

1) Grade III liver lac (R) lobe 998.2 ICD9, FY02
2) Total disruption (R) kidney 780.55 ICD9, FY02
3) T2 Paraplegia 344.1 ICD9 FY02
4) (L) thigh GSW @ fx 890.0 ICD9, FY02
5) Ex lap ō (R) nephrectomy / Repair liver lac 864.05, ICD9, FY02
6) Median sternotomy 780.3 ICD9, FY02

...TAL DAYS THIS FACILITY

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

☐ CHECK IF CONTINUED ON REVERSE

(b)(6)-2

...CER	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE ...	...BED ...	

MEDCOM - 2518

Potu: II (b)(6)-4 (Detainee)

(b)(6)-4

PATIENT'S DEPOSIT RECORD

For use of this form, see AR 40-2; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☒ *wish to make a deposit at this time.*

(b)(6)-2 LTC/AN (EMT-RN)

Patient's signature (or witness, if patient is unable to sign)

FUNDS & VALUABLES RECEIVED IN FULL *(Patient's or witness's signature and date)*

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

FUNDS

DATE	DEPOSITS		WITHDRAWALS		BALANCE		SIGNATURE

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS		WITHDRAWALS	
		DATE	SIGNATURE (Custodian)	DATE	SIGNATURE (Patient or intermediate individual)
001	Watch-1 (Black)	230403	SPC (b)(6)-2		
002	Jeans-1 (Black)	230403	SPC		
003	Belt-1 (Black)	230403	SPC		
004	Shoes-2 (Black)	230403	SPC		
005	Socks-2 (Black)	230403	SPC		

(b)(6)-2

DA FORM 1 DEC 77 3696 REPLACES EDITION OF 1 AUG 76, WHICH MAY BE USED. ★U.S.GPO:1991-0-301-988

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

See SF 558
for complete H&P available
@ this time.

PHYSICAL EXAMINATION

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

(b)

(b)(6)-2

ATE	IDENTIFICATION NO.	ORGANIZATION
230C703		

ve Name last, first, r medical facility)	REGISTER NO.	WARD NO.

Potus #

(b)(6)-4

(b)(6)-4

MEDCOM - 2520

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

LAST NAME	FIRST NAME	MIDDLE IN	L	ID NUMBER

DATE	NOTES
10/31/03 1330	Surgery ~~PT~~ Echo: ~~thrombus~~ clot, (+) BS/flatus Uss Agb L-CTA, CXR - no D CT (R) with 100cc CT (R) with 250cc CV-RLR ↓ ABL - mild dysfunction, wound healing P/ S/P GSW to lung (R) Nephrectomy - stable D/c 2 CT, continue (R) pleural tube ✓ CXR

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

)-00-634-4176

CHRONOLOGICAL RECORD OF MEDICAL CARE

)ICAL RECORD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2 Oct 03 0730	Surgery Note 20's yo ♂ who attempted partial puncture suicide GSW to (R) chest and abd, (L) thigh. Presents hypotensive & obvious paraplegia of lower extr. CXR - wnl. X ray left forearm, NAD. To fx transverse process (L) L2. To OR for emergent Exploratory [redacted] (b)(6)(2)
230 Oct 03 1130	Brief OR Note Prep, GSW to abd/chest Post op score (+) (1) Injury to (R) dome of liver (2) through and through injury To (R) Kidney (3) Large paraspinal abscess/lesion c̄ obvious transection spinal cord / Emergent Procedure, (1) Ex lap (2) Median Sternotomy (3) Removal (R) Kidney (4) Repair laceration diaphragm (R) with C c̄ overlying pack

(b)(6)-2

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

CHRONOLOGICAL RECORD OF MEDICAL CA

Medical Record

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

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

(B) Dehydrated / pulling (R) retroperitoneal

(b)(6)-2

Admitted - GETA, Feeling

Findings: total distribution (R) Kidney to thorax through injury, serous grade IV lac (R) of liver with mesenchyme on (R). Large Pentihal clysed to prox lacerations (R) & of spleen, entire op hypotension requiring massive transfusion, pressors of epi, dopamine and Vasopressin. No cardiac or lung injury.

Brain - ⊘

Path - (R) kidney

Condition - critical, survival?

(b)(6)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
23 Oct 03	0730: Arrived via ground to (b)(3)-1 Mosul, Iraq. Placed on monitors, clothing cut away, 100% O_2 (+) spontaneous respirations RT and full medical staff at bedside. Ø IV access at this time (upon arrival)
0730	HR: 104 BP: Unable to obtain ox: Unable to obtain Md starting central line (R) fem. Working on IV access
0735	HR: 94 BP: RR: ox: 99% IV 18G start (L) AC 1000cc ↑
0740	HR: 87 BP: RR: ox: 95% 1000cc in, #2 2 IVF ↑
0743	Succinylcholine 100mg IVP/Anes; pt orally intubated, 22 cm @ teeth Blood ↑ 1U PRBC ↑ via (R) Fem central line. Labs drawn & sent - Foley placed - U/A sent CXR
0750	HR: 94 BP: 96/43 RR: Bagging 100% ox: 100% Versed 2mg IV, Vec 10mg IVP #2 of 2 PRBC ↑
0757	HR: 101 BP: 85/38 RR: Bagging 100% ox: 99% Dopamine started 5mg/kg/min
0800	HR: 95 BP: 94/59 RR: Bagging 100% ox: 100% ↑ Dopa 10mg/kg/min (26.3cc) Dr (b)(6)-2 placed CT to (L) CW - Pt prepared for surgery

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

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

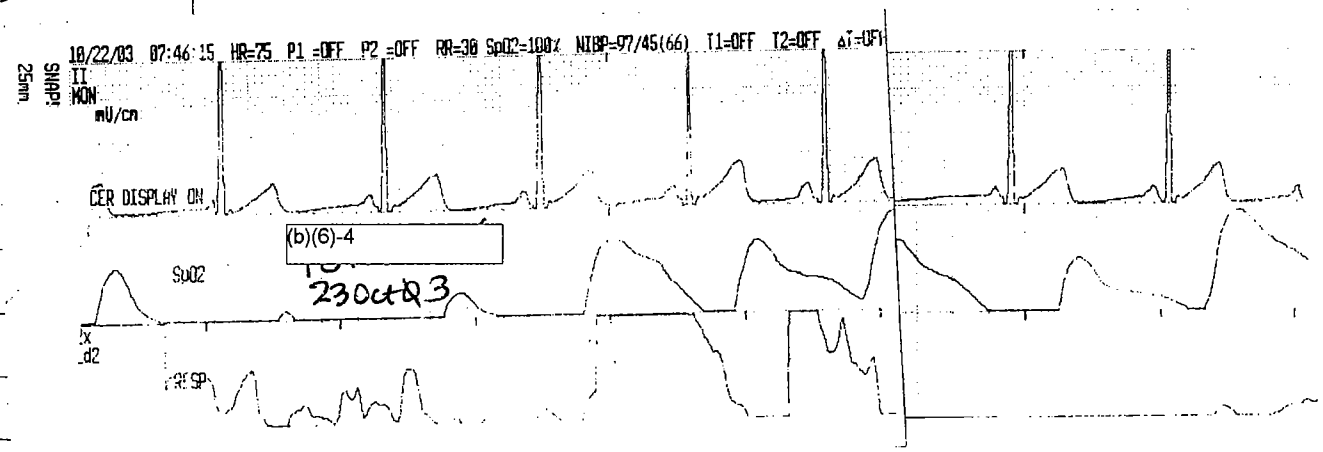
POTUS # (b)(6)-4

(b)(6)-2

MEDCOM - 2524

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
cont from front 23OctØ3 ØØØ5	Pt transported to OR. Sent along with patient. Ancef 1 GM IVPB & Tetanus 0.5cc injection. (b)(6)-2



3/327 HHC Scouts SPC Hopkins, Amari
Enemy drove off Interstate. Occupants exited car and begin to fire at Sniper teams located in OP. Snipers returned fire killing 2, Injuring 1, and 1 enemy escaped.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES		
DATE	23 Oct 03	NOTES	
Unit #1	BP	T (AX)	P
Pre (1950)	104/65	96° (AX)	92
1955	127/81	96°	89
2000	135/44	96.1	92
2005	123/45	96.1	87
End #1 2015 ~~2020~~ mj	134/73	96.3	91
Unit #2			
Pre 2025	142/58	96.3	91
2030	147/48	96.5	85
2035	150/82	96.8	90
2040	99/68	96.8	103
2055 ~~2100~~ mj	109/77	96.8	98

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)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10/24/03 1700	Surgery ND#1 POD#1
	Pt sedated, on vent, follows commands, supple extremities, No movement of lower ext
	Vss Agab
	Resp Good ABG → 40%, PEEP 5 TV 800 sats 100% no acidosis
	CXR-clear
	CT-⊘ air leak serous output
	CV- NSR/RRR
	Requiring Vasopressin / Dopamine
	Abd-⊘BS, nondistended
	No minimal output
	Renal-good UOP I/O ≅ equal
	Agab 13.3 WBC 16.9 PLT 102
	CR 1.3
	ALK⊘ 40 ALT 243 AST 242 Tbili 3.3
	O/P L2 Paraplegia / limited / (R) Nephrectomy
	(1) Contrin supportive care Hemodyne

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

Potus (b)(6)-4

DATE	NOTES
	② Maintain vent @ present settings
	③ Continue CT to suction @ 20 cm
	(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

540-00-634-4176

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDICAL RECORD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
25 Oct 03	Surgery IVD#2 POD#2
1400	Pt stable on Vent
	awake, alert
	Hemodynamics more stable
	Uss Aegis
	L-CTA [illegible] WOB on 40% FTO
	CXR-clear CT ⊘ airleak / ⊘ effusion
	CV-RRR S(1)
	sternum-stable
	Abd-⊘ BS, soft nondistended
	Trauma intact
	Renal-good UOP
	B/D (+) 1600
	WBC 12.3 PLT 96
	CR 1.3 Tbili 1.0 ALT 151 Alk ⊘ Ast 120
	K 3.6
	P/P S/P GSW (R) Nephrectomy / clinically
	T5 paraplegia
	(1) Δ Vent to IMV Rate 8 - continue weaning
	(2) Δ IV to D5NS @ 20 ml/hr @ 125 cc/hr
	(3) Vasopressin weaned to off
	(4) Weaning Vasopressin

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE [redacted] | RECORDS MAINTAINED AT [redacted]

SPONSOR'S NAME | SSN/ID NO. | RELATI

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

(b)(6)-4

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

Potus (b)(6)-4

Q

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10/27/03 0900	PT extubated last PM, breathing comfortably N. neuro Sx, (+) appetite VSS AF L-ETA [illegible] PEG 2L NC CT = 150 cmH2O 24hr CXR - mottled small (+) effusion CV - RRR, NSR Wound clean/dry/intact Abd - BS, nontender K 3.1 WBC 6.7 CR 1.2 Hgb 8.4 S/O (-) 800 A/P S/P GSW to Lwr (R) Neophrectomy (1) Clear liquids (2) D/C Foley (3) Sub Q heparin (4) K replacement [illegible]

(b)(6)-2

RELATIONSHIP TO SPONSOR	LAST	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)*

Pohms (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/3/03 0850	Surgery 24yo ♂ who presented in hypovolemic as well as spinal shock following 2 GSW to abdomen and (L) thigh. Upon eval was fluid resuscitated and started on pressors. PE revealed L2 paraplegia, gross hematuria and an acute abdomen. He was taken to the OR for Exploration. His injuries included a large stellate laceration to the (R) lobe of liver near the dome, which required extensive mobilization of the liver → this was completed through a midline laparotomy/median sternotomy for adequate visualization. Pt also had a devitalized laceration (R) kidney requiring nephrectomy. No bowel injury. A large bony deficit of the posterior spine required removal of viable fx and packing for control of hemorrhage along (R) posterior margin. Postoperatively the patient stabilized in 72 hrs and has done well since. Left chest tube was removed on last 2-3 days, CXR clear. Pt has had return of bowel function, tolerating regular diet and is ambulating

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)

DATE	NOTES
	Good training. Foley in place. No return of any neurologic function. By xray appears to be stable fx C5 in intact anterior/medial column. Pt should have CT cervical spine in place x 48 hrs. All surgical sites healing well. To be transferred to present marshall for questioning.
	(b)(6)-2

58-103 (See Instructions on Back of this Sheet) OJ #1 of 2 NSN 7540-01-075-3786

EMERGENCY CARE AND TR... ...NT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL			TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE		TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)	UNKNOWN	☐ PATIENT ☐ OTHER (Specify)
DAY	MONTH	YR.			ALLERGIES
3	OCT	03	0730		UNKNOWN

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: UNK

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: ON ARRIVAL

VITAL SIGNS			
TIME	0750		
BP	96/43		
PULSE	94		
RESP.	30	90% / FIO2	
TEMP.	—		
T. (Child)	100% BVM		

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

ORDERS	INITS.	TIME
1 L 2 BOLUS	MAN	0735/0740
2L NS ORIR		
MONITORS	MAN	0730
BC, T+C, UA	MAN	0743
NR, AB XO	MAN	0743
FOLEY	MAN	0743

ASSESSMENT/DIAGNOSIS: CSW, Thorax, abdomen

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)

Iraqi ♂ of unknown age brought to CSH via FLA in custody of [redacted] (SPC [redacted]) p̄ sustaining GSW to chest. Hemitic value over chest wound, no IV access on arrival

"AMPLE" History unobtainable

A - patent, grunting respirations
B - Breath sounds, chest rise symmetric, tachypnic
C - Intermittent thready peripheral pulses, active bleeding from (L) posterior thoracic chest wound
D - Moving upper extremities only; flaccid + unresponsive at lower extremities
E - Completely exposed, rolled and examined.

Succinylcholine 100mg IV - 0743/MAN
Vecuronium 10mg IV 0750/MAN
Versed 2mg IV 0750/MAN
Dopamine gtt - 0757/MAN
Ancef 1 gm IV sent to OR/MAN
Tetanus

Ventilations assisted by BVM, 16 ga IV cath (L) FA, 8.5 F cordis placed (R) femoral vein by Dr. [redacted]

RSI ε 100mg succinylcholine, intubated by MAT [redacted] 8.5 ET tube via DL

(L) chest tube Thoracostomy placed by Dr. [redacted]

2,500 cc crystalloid and 2 units Emergency release blood administered and transfused to OR

(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)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

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).

(1 of 2)

Porus# [redacted]

[redacted]

SIGNATURE OF PROVIDER [redacted] UTZ, MC

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

PUXR - (L) Subcardiac missile fragment

Abdo - (L) paraspinal missile fragment, loss of psoas shadow

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMP

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	

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

CURRENT MEDS. (Tetanus immunization and other data)

1 of 2

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

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

HOME TEL.E. NO. (Inc. area code)

See PAGE

CHIEF COMPLAINT(S) (Include symptom(s), duration)

SEX

AGE

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME			
BP			
PULSE			
RESP.			
TEMP.			
WT. (Child)			

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

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS
1-SW Thorax and Abdomen

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

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

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

2° SURVEY -

GENERAL: minimally responsive
moving upper extremitys only, weakly
INTEG: Pale, cool, clammy
HEENT: No obvious injuries
OS enucleated (old injury)
OD pupil dilated, reactive
LUNGS: Tachypneic, grunting
Chest rise, breath sounds symmetric
Penetrating wounds (2) anterior paraesternal
(2) posterior-lateral thoracic
CV: Heart sounds distant
BACK: Penetrating wound (2) posterior lateral only
ABDO: Rigid, tender
GU: nl ♂ EG ∅ trauma
RECTAL: ∅ blood; flaccid tone
EXTREM: ∅ obvious trauma,
2E's apparently insensate
NEURO: Moving upper extremities only initially, weak, purposful movements

18.2 | 13.8 / 40.1 | 414

134 | 100 | 1.9 / 4.3 | 318 / 16

UA - SG = 1.030 ∅ glucose ∅ ketone
(large blood) 0-5 WBC/TNTC RBC

(CONTINUE (b)(6)-2

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

(2 of 2)

IRAQI DETAINEE

b(6)-4

SIGNATURE OF PROVIDER AND STAMP

b(6)-2

LTC, MC

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

TO OR

EMERGENCY CARE AND TREATMENT

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and IC48

CRITICAL CARE FLOW SHEET

(b)(3)-1

LOS DATA	
DOA	23 oct 03
DOS	23 oct 03
POD	DO8

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		N/A	
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	23 oct 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

MEDCOM - 2535

		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		1					1				1	
	RADIAL L												2		1					1				1	
	DORSALIS PEDIS R												2		1					1				1	
	DORSALIS PEDIS L												2		1					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 4 8					1 4 8				1 3 8	
EDEMA													Ø		Ø					Ø				Ø	
HEART SOUNDS (Clear, Regular, No Rubs, No Murmurs)													✓		✓					✓				✓	
HEART RHYTHM (Normal Sinus Rhythm, no ectopy)													SR/SB		SR					ST				SR	
SWAN GANZ CATHETER (Zeroed & calibrated)																									
ARTERIAL LINE (zeroed & calibrated)													✓		✓					✓				✓	
HYGIENE	BED BATH																								
	FOLEY CARE																								
	ORAL CARE																								
MOBILITY	BEDREST												✓		✓										
	~~BSC~~ LOGROLL												✓											✓	
	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	
BOWEL SOUNDS (active all quads)													Ø		Ø					Ø				Ø	
NG / DOBHOFF PLACEMENT VERIFIED													✓		✓					✓				Ø	
RESIDUAL ASSESSED																									
Ph																									
FOLEY CATHETER PATENT													✓		✓					✓				✓	
VOIDING CLEAR, YELLOW URINE q.s.													✓		✓					✓					
SKIN INTEGRITY	No Breakdown																								
Midline ABD	Surgical Wounds												✓		✓					✓				✓	
	Rashes, Lac's, etc																								
DRESSING (Dry & Intact: specify site below)																									
#1 ABD													✓		✓					✓				✓	
#2																									
#3																									

INVASIVE LINES	SITE	DATE INSERTED	DESCRIPTION (SITE, DSG.)
PIV 18ga	(R) hand	23 Oct	CDI
TLC	(R) fem	23 Oct	CDI – D/C'd 23 Oct 03
A-line	(L) radial	23 Oct	CDI
Cordis	(L) groin	23 Oct 1800	CDI

(b)(6)-2

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: 23OCT03

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												1		1				4	4				4	
B. BEST VERBAL RESPONSE (5) Oriented (4) Confused (3) Inappropriate Verbal Response (2) Garbled (1) No Response												T		T				T	T				T	
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												1		1				6	6				6	
GLASGOW COMA SCALE (A+B+C)												2T		2T				10T	10T				10T	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) R												6+		7+				6+	6+				5+	
PUPIL RESPONSE Size (mm), React to Light (+) No Response (-) L												N/A		N/A				N/A	N/A				N/A	
MOVEMENT (See Motor Function Scale at Top of Page) RUE												Ø		Ø	1	3		3	3				3	
LUE												Ø		Ø	1	3		3	3				3	
RLE												Ø		Ø	Ø	Ø		Ø	Ø				Ø	
LLE												Ø		Ø	Ø	Ø		Ø	Ø				Ø	
GRIP (S) Strong (W) Weak (-) absent R												—												
GRIP (S) Strong (W) Weak (-) absent L												—												
RESPIRATIONS REGULAR												V		V				V	V				V	
IRREGULAR												E		E				E	E				E	
UNLABORED												N		N				N	N				N	
LABORED												T		T				T	T				T	
SHALLOW																								
RETRACTIONS																								
BREATH SOUNDS (5) Clear (4) Crackles (3) Rhonchi (2) Wheeze (1) Diminished RUL												5↓		5/1				5					5	
LUL												5↓		5/1				5					5	
RLL												5↓		5/1				5					5	
LLL												5↓		5/1				5					5	
BOTH BASES												1		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												700		700		800		800					800	
FiO2												1.0		1.0		.6	.4	.4					.3	
RATE (SIMV/CMV)												✓		10		10		10					10	
PEEP / CPAP												+5		5		5		5					5	
PRESS. SUPPORT																								
OXYGEN DELIVERY DEVICE NC (l/min)																								
FM (l/min)																								
ETT = 8.5 NRBM (l/min)																								
ETT 22 cm gums																								
ETT CARE / POSITION CHANGE																								
ETT / NT SUCTIONED																							RT	
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																	
1100																	
1200	35	81	10/10	136/59		136/59	78										
1300	35	81	10/10			136/59	78										
1400	90.8 A	77	12/10	95/52	100	100/50	63										
1500	91.3 A	81	10/10	100/64	98	100/53	66										
1600	92° A	93	10/10	123/67	100	120/70	88										
1700	93 A	100	16/10	118/64	100	126/66	84										
1800	94.8 A	99	15/10		100	69/44	58										
1900	95.6 A	99	10/10	115/65	100	120/65	79										
2000	96° A	89	16/10	127/81	100	128/70	86										
2100	96.8 A	81	10/10	123/86	100	114/75	89										
2200	97.8	97	12/10	114/75	100	136/76	89										
2300		90	10/10	93/-	100	93/53	64										
2400		76	10/10	132/77	100		100										

	INTAKE									OUTPUT						
	LR	D5W	V250	PRBC	IVPB				Total	Urine	CT #1/#2	CT #3/#4	NGT		Total	COMMENTS
0100																
0200																
0300																
0400																
0500																
0600																
0700																
0800																
8 HR									8 HR.						3 HR	
0900																
~~1000~~ OR	OR 8500	Alb 100		OR 600						OR 200			EBL OR 1000			
1100																
1200	150 / 150	7 / 7	15 / 15							400 / 400	#1 0 / #2 20	#3 0 / 350 #4				
1300	150 / 300	7 / 14	15 / 30	401 / 401						650 / 650	#1 0 = 0 / 45 65	340 = 50 #4 70 / 420				
1400	150 / 450	7 / 21	15 / 45	472 / 873	50 / 50					150 / 800	#1 10 / 0 40	40/90 / 125/545				
1500	150 / 600	7 / 28	15 / 60		100 / 150					225 / 1025	0/0 / 15/120	3 20 / 110 60/205				
1600	150 / 750	7 / 35	15 / 75		1000 / 1150					325 / 1350	0/0 / 15/135	75 125 / 20 625				
8 HR	750	35	75	873	1150				16 HR. 2883	1350	0 / 135	125 / 625		1000	16 HR. 3235	- 352
1700	150 / 150	7 / 7	20 / 20		1000 / 1000					350 / 350	0/0 / 20/20	20/20 / 80/80				
1800	150 / 300	9 / 16	30 / 50							200 / 550	See separate sheet attached					
1900	150 / 450	12 / 28	30 / 80							200 / 750						
2000	150 / 600	15 / 43	38 / 118	414 / 414						120 / 870						
2100	150 / 750	15 / 58	30 / 148	417 / 831	500 / 1500					200 / 1070			min.			
2200	150 / 900	15 / 73	30 / 178		50 / 1550					175 / 1245						
2300	150 / 1050	12 / 85	15 / 193							125 / 1370						
2400	150 / 1200	15 / 100	37.5 / 240.5							200 / 1570	0 / 170	105 / 285				
8 HR	1200	100	240.5	831	1550				24 HR. 3921.5	1570	0 / 305	530 / 880			24 HR 3985	

6220

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
23OCT03 1300hrs			Pt discharged from recovery status see flowsheet for details. Dr [redacted] MD see pt #1 of 2 w/ PRESS ~~SBP~~ HR/BP continue labile, titration of IV gtts required. CT dry contents moderate, UOP adequate (b)(6)-2
23Oct03		1730	Pt's BP ↓ to sys 70s → 80s ~1600. Vasopressin ↑ to .30/min and 1 Liter RL given IVP. Received 4mg MSO4 and 2mg Versed @ 1515 and 1525. Pt's sys BP ↑ to >100 c̄ bolus + ↑ vasopressin. Dr [redacted] MD to see pt → ↑ vasopressin to .4 u/min and ↑ dopamine to 9 ml/hr (3 mcg/kg/min) using 80 Kg as estimated pt's weight. Sys BP 110-120 @ this time. [redacted] (b)(6)-2 OTJ AN
23Oct03		1930	↓↓ BP 60's/40's by A-line + cuff. (R) femoral cordis found completely out, hand/wrist restraints intact c̄ pt hands @ side. Minimal blood loss from cordis site, IV fluids running onto bed. Pressure held to (R) femoral site x 5 min, no hematoma noted. (L) femoral cordis inserted per Dr [redacted] (b)(6)-2 s complications, good blood return. Vasopressin + dopamine titrated to ↑ sys BP >100. Pt was awake, responding and moving (B) arms while BP was in the 60s. Hands wrapped c̄ Kerlix to protect pt + prevent him from pulling out invasive lines. [redacted] (b)(6)-2 MAJ AN
23Oct03		2200	Recvd supine. USS. BP in 150's. Eyes closed. Resp. per vent. Chest rises & falls equally bilat. Restraints intact. Assess completed. Vent settings TV 550. PEEP 5, F_IO_2 40%. Pulses barely palpable 2° Dopamine. Cont to monitor [redacted] (b)(6)-2 SGT AN
23Oct03		2300	BP ↓. ↑ Dopamine + Vasopressin p̄ MSO4. Continue to monitor. Pt asymp. c̄ ↓ in BP. [redacted] (b)(6)-2 SGT AN

'est tube Output - 22 'ct 03

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: CONTINUED POST-ANESTHESIA CARE UNIT FLOW SHEET

OTSG APPROVED: 17 Jan 80

	VITAL SIGNS					PAR SCORE						OTHER		
Time	B/P	P CT1	R CT2	O_2Sat CT3	T CT4	Act	Resp	Circ	LOC	Skin	PARS	Other	Neuro-Vascular	COMMENTS
~~PRE-OP~~	/												Extr: L R Upper Lower Pulse: DP PT RAD	
1700	/	0/0	20/20	20/20	80/80								Blanche Pulse ___ Warm Moves Y N	
1800	/	0/0	20/40	15/35	30/130								Blanche Pulse ___ Warm Moves Y N	
1900	/	0/0	40/80	40/75	40/170								Blanche Pulse ___ Warm Moves Y N	
2000	/	0/0	50/130	10/85	30/200								Blanche Pulse ___ Warm Moves Y N	
2100	/	0/0	20/150	0/85	20/220								Blanche Pulse ___ Warm Moves Y N	
2200	/												Blanche Pulse ___ Warm Moves Y N	
2300	/	0/0	40/190	20/105	35/255								Blanche Pulse ___ Warm Moves Y N	
2400	/												Blanche Pulse ___ Warm Moves Y N	
24 oct 0100	/				75								Blanche Pulse ___ Warm Moves Y N	
0200	/	0/0	30/30	30/30	75/75								Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	
	/												Blanche Pulse ___ Warm Moves Y N	

(Continue on reverse)

PREPARED BY *(Signature and Title)* (b)(6)-2 MAJ AN

DEPARTMENT/SERVICE/CLINIC

DATE

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 ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT