05 July 03 Bed # 2

Patient's Name: EPW #[redacted]

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		110/76												100/60										
TEMP		97.6												97.9										
HR		74												65										
RR		16												18										
SAO2		100												99										
FIO2		RA												RA										
INPUT		0																						
PO		100		240		240			100															
IV		0																						
NGT		N/A																						
DB				100						100														
TURN Q 2	N/A	PT		moves		himself																		
												800												
TOTAL				340		640				[illegible]		[illegible]												
OUTPUT																								
URINE		300			375					350		500												
NGT																								
STOOL				X1																				
TOTAL		300			675					35		1500												
BALANCE																								
Initials																								

MEDCOM - 12641

Patient Name: #[redacted] 2 JUL 03

Time	~~04~~	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
	0600																							
BP	104		98/61	105/70					108/65					105/65				110/60				100/55		
TEMP	98.4		97.4	98					97.4					97.3								97.8		
HR	46		63	48					52					50				48				45		
RR	16		14	16					16					18				20				22		
SAT	97		97	95					96					97				98				98		
[illegible]	RA		RA	RA										NA				NA				NA		
	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~	~~100~~															
INPUT	NS	NS	NS	NS	NS	NS	NS	NS	NS															
PO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO											
IV (LR 100)	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT	Ø		Ø																					
IVPB	Ø		Ø	50								50								50				
TURN Q 2	-																							
																				150				
													1500	1500	1600	1700	1800	1900	2000	2150	2250	2350	2450	2550
TOTAL	100		200	350					950				1550											
OUTPUT	Ø		Ø																					
[illegible]IE				125					350							200			250				375	275
[illegible]																								
[illegible]L																								
																							1400	1475
TOTAL				125					475				475			675			1025					
BALANCE	Ø		Ø																					

IN 2550

OUT 1475

MEDCOM - 12642

Patient Name: #[redacted] 1842 - 2842

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP																				105/61	94/53	94/55	93/56	
TEMP																				96.5				
HR																				48	48	45	50	50
RR																				18	16	11	20	18
SAO2																				97	98	96	97	98
FIO2																				RA	RA	RA	RA	RA
T																								
IV																				100	100	100	100	100
NGT																				50				
IVPB																								
TURN Q 2																								
TOTAL																				150	100	100	100	100
																				150	250	350	450	550
OUTPUT																								
URINE																							150	
NGT																								
STOOL																								
TOTAL																							150	
BALANCE																								

IN 550

OUT 150

MEDCOM - 12643

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

12 13 14 15

PULSE (0) | TEMP. F (°)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

TEMP. C

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

[redacted]

b(4)-4

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 2003 | DAY 5 6 7 8 9 10 11 | HOUR

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

TEMP. F	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

PULSE: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Data only when so ordered

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

REGISTER NO.

WARD NO. TCW2

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

b(6)-2

Ward/Section: EMT	JESTR[redacted] Dr. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI: Eph		DATE: 17 Jul 03	TIME: 2145	SSN/DOB: [redacted] SSN: b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	88	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	761	39-380 u/l (M) 30-190 u/l (F)
NA^+	142	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	105	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE: 17 Jul 03	LAB ID NO.:

[redacted]

b(6)-2

PT PTT

12.2 / 22.4

b(6)-2

d/Section: EMT

REQUESTING PHYSICIAN: DL [redacted]

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

T, FIRST, MI.

DATE: (July 3

TIME: 2715

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

(Hematology) CBC

EST	RESULT	REF. RANGE
C	7.2	4.8-10.8 x 10^3
C	4.56	4.7-6.1 x 10^9
)	12.3	14-18 g/dl (M) 12-16 g/dl (F)
	39.7	42-52% (M) 37-47% (F)
V	87.0	80-94 fl (M) 81-99 fl (F)
	274	130-500 x 10^3 verified
aph %	26.0	20.5-51.1%

Hematology Manual Differential

s		Mono	
ds		Eos	
aph		Baso	
p		Imm	
C ph			

n atocrit		42-52% (M) 37-47% (F)
Rate		
er		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

ST	RESULT	REF. RANGE
		9.8-13.6 secs
TT		21-34 secs
imer		<20 ug/ml
)		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

MARKS:

PORTED BY: DATE: LAB ID NO.:

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	Dose	
Fentanyl	(mcg)	50 (200)
Lidocaine	(mg)	40
Propofol	(mg)	150 50
Succ	(mg)	80
	( )	
	( )	
Volatile agent: Iso	% del / % e.t.	1.5 1.5 1.5 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 2 2 2 10

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

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

TOTALS	
250	
40	
200	
80	

TOTAL BILL: MT

TOTAL URINE: Ø

FLUIDS – SUMMARY
CRYSTALLOID – 300
COLLOID – Ø
BLOOD – Ø

LINE site 20G (R) A Warmed; 18G (L) A Warmed; OR Warmed; Warmed

LP Dcd X
LP #1

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: —

INITIAL DATA: BP – 108/74; HR – 70

BLOOD CHECK: OK? – Y N

PATIENT REVIEW: OK for PROCEDURE? TJ; TIME – 1915

TIME → 1930 . 2000 . 30 . 2100 . 30 . 2200

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

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

VT – ml		600 650 330 300
f – breaths/min		10 6 9 9
Peak inf pres / PEEP		20 20
MODE – S(pon), A(ssist), C(on)		S C C S S
BP/Auto Cuff	ET CO2 (torr)	50 35 31 41 33
BP / oth	FIO2 (Frac or %)	0.89 0.89 0.89 0.89 0.89
ART line	SpO2 (%)	100 100 100 100 100
Steth – PC/ES	ECG	SR SR SR SR
Gas analyzer	TEMP – site	Axilla Lip
	N-M Block (T/4)	BS X1
Warming blkt	Wool Blanket	
Conv warmer		

Mark with letters & symbols, explain under REMARKS

EVENTS: 1 2 3 4 5

Position: 1

REMARKS – Code drugs with numbers, events with letters

1. Pre-op assessment, NPO status explained to pt to go to OR
2. Room monitors. O2 induced, eyelids taped, see airway management
3. Zofran 4mg IV
4. To > 4mg/kg; RR > 8 & < 30 BPM. Operational; Responsive; Extubated; No complications
5. To Elite & To ICU. Report to RN.

RECOVERY AT 2030
PACU CO 1 (Specify)
OTHER T 97.2
CONDITION: Stable and alert
RESP – 20 SpO2 – 99
BP – 128/72 HR – 76

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1925	1935	2045
PROC	Ready	Begin	End
	1945	2055	2025

PROCEDURES and CPT Codes: I&D (R) foot & (L) hand

ANESTHETIC TECHNIQUES: GETA

AIRWAY MANAGEMENT: DL x 1 MAC 4. 8.0 styletted ETT 22cm @ lip + BBS. Grade 1 view. Post ETCO2

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

EPW # [redacted]

D(W)-4

D(W)-2

SURGEONS [redacted]

CRNA

MAJ [redacted] – ANESTHESIA

PROCEDURE LOCATION 2

DATE 6 July 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 12649

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

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Midazolam (mg)	<2.5>	
Fentanyl (µg)	50	25
Ketamine (mg)	10 - 10	
Propofol (R)	50 - 50	
( )		
( )		
VOLAT AGENT: Iso % del / % e.t.	1.5 1.5 X	
AIR L/Min		
N2O L/Min		
O2 L/Min	10 2 2 10	

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

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

FLUIDS: LINE site 20G (R) A ☐ Warmed — D/C'd; 16G (L) Arm ☐ Warmed — SL #1; ☐ Warmed; ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT: 39.7

INITIAL DATA: BP – 90, 60; HR – 55

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME – 1330

TIME → 1345 1400 . 30 . 1500

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

220 200 180 160 140 120 100 80 60 40 20

VENTILATION: VT – ml 400 330 600; f – breaths/min 18 12 12; Peak inf pres / PEEP; MODE – S(pon), A(ssist), C(on) S S S S

MONITORING AND PROCEDURES: BP/Auto Cuff; BP / oth; ART line; Steth – PC/ES; Gas analyzer; EtCO2 (torr) 45 49 50; FIO2 (Frac or %) 0.71 0.71 0.71 0.71; SpO2 (%) 100 100 100 100; ECG SR; TEMP – site AU Available; N-M Block (T/4) BS +; Warming blkt x1; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4); Position → supine, 66-2

PROCEDURES and CPT Codes: I + D (R) foot + (L) hand-finger

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

FPW # [redacted]

b(6)-4

TOTALS: 2.5 / 75 / 20 / 100; TOTAL FLUID: MID; TOTAL URINE: Ø

FLUIDS SUMMARY: CRYSTALLOID – 300; COLLOID – Ø; BLOOD – Ø

REMARKS — Code drugs with numbers, events with letters

(1) Pre-op review of systems. Lungs – CV – airway – NPO – confirmed since 0 Glycopyrrolate 0.2 mg IV
(2) Room monitors O2 Saturation TTE
(3) Zofran 4 mg IV for c/o N+V
(4) A, A, responsive removed nasal airway himself. To Cliff + to ICU Report to nurse

RECOVERY AT 1450: PACU ICU 2 (Specify); OTHER T-95.4; CONDITION: Stable, arousable; RESP – 20's SpO2 – 96; BP – 124/8 HR – 63

ANES: Start 1330, Room 1345, End 1455

PROC: Ready 1400, Begin 1418, End 1440

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: CR 9mm; [redacted] 7FR; head tilt, R chin lift

SURGEONS: [redacted] b(6)

PROCEDURE LOCATION: 2

DATE: 9 July 03

PAGE 1 OF 1

[redacted] MEDICAL R[redacted]NESTHESIA

[redacted] OP 376 REVISED Jan 99

[redacted]ATIENT REC[redacted]

☆ U.S. GPO: 1999 – 528-336/10085

7/12/03: No Δ in pt status prior anesthetics. New preop deferred.

Sir
Pla
SA.

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
Versed	(mg)	2.5
MSO4	(mg)	4 2
Propofol	(mg)	100
	( )	
	( )	
	( )	
VOLAT AGENT: Halothane	% del / % e.t.	2.0%
AIR	L/Min	
N2O	L/Min	
O2	L/Min	

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: 1 2 3

FLUIDS

LINE site		
20g LFA	☐ Warmed	RL Dra
18g RFA	☐ Warmed	200
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE –

TOTALS	TOTAL FLUID
2.5	min
6	
	TOTAL URINE
	Ø

FLUIDS – SUMMARY
CRYSTALLOID – 200
COLLOID – Ø
BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters
1) To room, SOC monitors, prep.
2) Smooth IV induction
3) To recovery stable.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 60 KG / LB

HEMATOCRIT: —

INITIAL DATA: BP – 120/71; HR – 58

EQUIP CHECK: OK? – Y / N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME – 0705

TIME → 08 × 30 × 09 × 30

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

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

VENTIL

VT – ml	
f – breaths/min	16 14
Peak inf pres / PEEP	
MODE – S(pon), A(ssist), C(on)	S S

MONITORS / ACCESSORIES

✓	BP/Auto Cuff	✓ ET CO2 (torr)	36 36
	BP / oth	✓ FIO2 (Frac or %)	0.9 0.9
	ART line	✓ SpO2 (%)	100 100
	Steth- PC/ES	✓ ECG	SB SB
	Gas analyzer	TEMP- site	
		N-M Block (T/4)	
	Warming blkt		
	Conv warmer		

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

RECOVERY AT: PACU / ICU / OTHER (Specify) 1
CONDITION: 96 2
RESP – SpO2 – 98
BP – 95/61 HR – 52

TIME TRACKING

	Start	Room	End
ANES	0750	0800	0830
	Ready	Begin	End
PROC	0802	0807	0815

PROCEDURES and CPT Codes: Washout 1+ hand & R+ foot

ANESTHETIC TECHNIQUES – Describe block technique under Remarks: GM

AIRWAY MANAGEMENT – Intubation route, blade, technique, comments: Ears taped, #7 OA, easy mask.

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

EPW # [redacted]
32 yo b/w-4

SURGEONS: [redacted] b/w-2

ANESTHETISTS: [redacted] MAJ, CRNA
[redacted] RD – ANESTHESIA

PROCEDURE LOCATION: 1-1
DATE: 7/12/03
PAGE 1 OF 1

WAMC OP 370 REVISED Jan 99

MEDCOM - 12651

☆ U.S. GPO: 1999 – 528-336/10085

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

Age 32 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R) pinning foot
SURGICAL SERVICE: Ortho
NPO SINCE: MN

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

HABITS:
TOBACCO: Ø
ETOH: Ø
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

() Ancef 1gm IVPB 8a
() ____
() ____
() ____
() ____
() ____

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

LABORATORY STUDIES:
HB/HCT: 12.3, 39.7
U/A: ____
OTHER: ____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 130/61 HR 56 R 12 T 98.1
Pain Scale 0-10 ____
HEENT - Teeth intact · Cavity (R) Loc molar
Trachea Midline
TMJ/Neck FROM; Pain (R) mech
Oropharnyx MPI
Nares patent
CHEST: CTA (B)
CARDIAC: RRR (-) Ø
EXTREMITIES:
IV Access: (R) FA 18G PIV
Ulnar Filling: ____
BACK: ____
OTHER: ____

① GSW (R) foot ② infected wound ③ pulley purge

NPO Since MN

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

Speaks little English. Discussed to OR for surgery. Pt understands

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

b(6)-2

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: [redacted] CRNA/MAJ Date: 2 July 03 Time: 0815 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ____

EPW# [redacted] b(6)-4

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
MSO4	( )	10-10
Versed	( )	50
Propofol	( )	150
	( )	
	( )	
	( )	
VOLAT AGENT 150	% del / % e.t.	x/1.5/2.0/1.5/2.0/x
AIR	L/Min	
N2O	L/Min	
O2	L/Min	5/5/4/4/4/10

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

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

TOTALS	
20	
50	
150	

TOTAL SPA: MIN

TOTAL URINE: Ø

FLUIDS – SUMMARY
CRYSTALLOID – 800
COLLOID – Ø
BLOOD – Ø

FLUIDS: LINE SITE 18g (R) FA — Warmed (900ml) — Warmed NS — 800 — Warmed — Warmed

LOSSES: EST BLOOD LOSS — URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 60 KG LB

HEMATOCRIT:

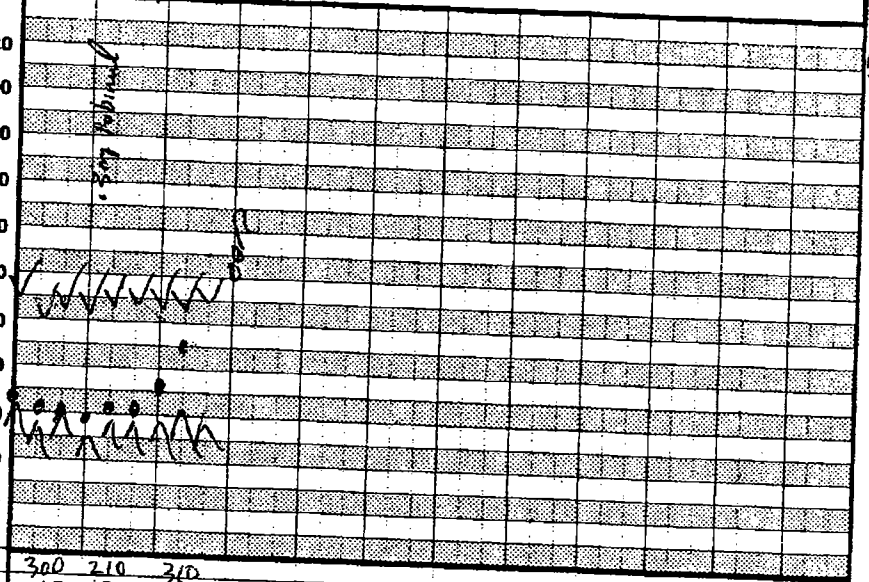
INITIAL DATA: BP – 124/70 HR – 88

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME – 1008

TIME → 1015 1030 x 1100

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



VT – ml	300	210	210
f – breaths/min	12	12	14
Peak inf pres / PEEP	/	/	/
MODE – S(pon), A(ssist), C(on)	S	S	S
ET CO2 (torr)	44	53	50
FIO2 (Frac or %)	.76	.76	.76
SpO2 (%)	100	100	100
ECG	SR	SR	SR
TEMP- site	Axil		
N-M Block (T/4)			

MONITORS & ACCESSORIES: BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

REMARKS – Code drugs with numbers, events with letters

0950 PT ID, CHART REVIEWED, Ø Δ from PREOP 2400.

1003 RM, O2, MONITORS

1100 OOR TO ICU 2

1110 RPT TO SGT [redacted]

RECOVERY AT 1109
PACU ICU ____ (Specify)
OTHER ____
CONDITION: stable
RESP – 14 SpO2 – 97
BP – 177/80 HR – 97

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES	0950	1003	1115
PROC	Ready	Begin	End
	1010	1029	1059

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

PROCEDURES and CPT Codes: I & D Ankle

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA ⊤ mask

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: OA in place – mask

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

[redacted]

[redacted] CA CRNA

PROCEDURE LOCATION: OR 1

ESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

32 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

DSED PROCEDURE: I&D (R) Foot + (L) hand GSW (R) FOOT
ICAL SERVICE: ORTHO
INCE: 1200 NOON

ASA Physical State 1 2 3 4 5 E
WT: 68 (KG/LB) HT: ____ IN.
ALLERGIES: NKDA

S:
ACCO: ____
ETOH: ____
RUGS: ____

ENT MEDICATIONS:
dered as premed

EDICATIONS:
Yes (@ ____ Hrs) /CC
- ____ mg IV IM PO
- ____ mg IV IM PO
- ____ mg IV IM PO

RATORY STUDIES:
T: 12.3 / 39.7
R: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 108/79 HR 78 R 20 T 97.6 6 July 03
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MPT
Nares Patent
CHEST: Scarring CTA (B)
CARDIAC: S1 S2 66-2 RRR (-)
EXTREMITIES:
IV Access: 18g RUE / 20G (R) A
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 1200

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

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a [redacted] legal guardian.

b(6) 2 [redacted] CRNA/MAJ 6 July 03 1921
[redacted] CPT CRNA Date: 3 JUL 03 Time: 1000 Hrs

ANESTHESIA [redacted] AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

1: ____ Date: ____ Time: ____ Hrs

t Identification: (Ward) ____

[redacted] b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

EDICAL RECORD

AUTHORIZED FOR LOCAL RE

PROGRESS NOTES

DATE	NOTES
9 Jan 03	On the Op Table.
	Pre-Op Dx - (1) ABSCESS (R) FOOT (2) LEUKOPENIA (L) SF
	Post Op Dx - same
	Procedure - (1) I+D (R) FOOT (2) I+D (L) SF
	Surgeon - [redacted] b(6)-2
	ANESTHESIA - MAC
	ANESTHESIOLOGIST - MAJ K
	Findings - (R) foot abscess. Abscess getting smaller. Packed wound with 1/4" NW GAUZE. (L) SF body some slight pus. Sutures opened irrigated NW-GAUZE.
	PLAN - IV ABX. Dressing changes daily.
	b(6)-2 [redacted]

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

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

EPW# [redacted]

b(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICU 2 | ROOM NO. | BED NO.

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

2323 | 1 JUL 03

Admit to ward
Dx s/p GSW to hand / foot
Condition stable
Diet NPO after midnight
NF LRC 100 cc/hr
Ancef 1gm q 8° IV
Neuro: GPW precaution.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

Meds:
MSO4 2-5mg IVP q 3° PRN
Phenergan 12.5mg IVP q 6° PRN Nau
Ambien 10mg PO q HS PRN
Splint to (R) leg.
Splint to (L) hand
to OR in AM

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NKDA

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

b(6)-4

DATE OF ORDER: 3 JULY 03 TIME OF ORDER: 1100 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PREVIOUS ORDERS
2. S/P ETO (R) FOOT + (L) WRIST
3. CONTINUE PCA
4. VS QAHS
5. UP AD LIB, NWB ON (R) — 7/3/03
6. REGULAR DIET

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

Done 7. N.L. AT 125 CC/HR. KEEP 20 CC WITH FLUSH P.O. WELL — 5/10

Done 8. ADD CIPROFLOXACIN 500 mg P.O. BID.

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

DATE OF ORDER: 3 July TIME OF ORDER: HOURS

b(6)-2 [redacted]

D/C MSO4

Percocet 1-2 po q4-6° PRN pain

Saline lock IV

7/3/03

NURSING UNIT | ROOM NO. | BED NO.

[redacted] / NURSING

PATIENT IDENTIFICATION

EPW b(6)-4 [redacted]

DATE OF ORDER: 5 July 03 TIME OF ORDER: HOURS

24° chart ✓ done 04 July 03 @ 0340 m2

Transfer to KCW2

Resume Previous orders.

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

APV [redacted] / NURSING

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JU[redacted] WHICH MAY BE USED

b(6)-2

[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

b(6)-2 noted [redacted] 1049

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

DATE OF ORDER: 6 July 03 TIME OF ORDER: 0700 HOURS

LIST TIME ORDER NOTED AND SIGN

NPO

✓ for warfarin today

[redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
		24°

DATE OF ORDER: 6 July 03 TIME [redacted] 2000 HOURS

noted 21:15 [redacted]

Transfer PACU → ICW2

Up Bed (B) Foot / (O) Head

Strictly

Adm By Dret

IV/IV with PO

Resume [redacted] meds

24° V done [redacted]

PATIENT IDENTIFICATION

24° V's on [redacted] ICTAN 7-8-03 2300 [redacted] b(6)-2

[redacted]

b(6)-4

07 July 03 1000 [redacted]

NPO NOW

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER: 9 July 03 TIME OF ORDER: 1430 HOURS

1. Resume planned orders ✓
2. Regular diet ✓
3. N L R at 125 cc/hr. Hep lock when taken PO. ✓
4. S/P I+D (R) foot ✓
5. To ICU → ICW2 ✓
6. Dry dressing [redacted]

NURSING UNIT	ROOM NO.	BED NO.
24° Vs	[redacted]	

noted [redacted] 1030

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.

b(6)-2

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		11

DATE OF ORDER: 12 JAN 03 TIME OF ORDER: 0820 HOURS

LIST T ORDE NOTED SIGN

[redacted]

1. RESUME PRIMIDONE ORDERS
2. S/P I+D (R) FOOT, (L) HAND
3. RESUME DIET
4. IV: 2L OF 125 cc/HR
5. DRAW DAY DRESSING CHANGES
6. BOP LOCK IV WHEN TOLERATING PO INTAKE

12 JAN 03

PATIENT IDENTIFICATION

[redacted] 24 VS

[redacted] TIME OF ORDER: 7-12-[redacted] 2342 HOURS [redacted]

b(6)-2

b(6)-4

b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		11

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER: 14 JAN 03 TIME OF ORDER: 1610 HOURS

b(6)-2 [redacted]

1. D/C IV
2. D/C GLUCOSE
3. KEFLEX 250 mg Q 10 P.O.
4. MOV D/C TO FPW CAMP

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		11

b(6)-2

[redacted] 24 VS [redacted] 4/AN [redacted]

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DAT[redacted] 14 03 TIME OF ORDER: 2350 HOURS

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		11

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

b(6) 2

Green Sheet

the proponent agency is the Office of The Surgeon General. MO. 7 YR 2003

RIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18
3	[redacted]	VS routine	05	[redacted]			
			13	[redacted]			
			21				
			/				
3	[redacted]	regular diet	07	[redacted]			
			12	[redacted]			
			17	[redacted]			
			/	[redacted]			
Co	[redacted]	up ad lib - NWB	05	[redacted]			
		(L) leg	13	[redacted]			
			21				
			/				
9	[redacted]	dry dsg Δ QD	18	[redacted]			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P GSW to hand & foot
S/P I&D (L) hand / (R) foot

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

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

b(6)-8

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. Jul Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	2	3	4	5	6	7	8	9	10	11	12	13	14
2 Jul	[redacted]	Condition: Stable	05	/	[redacted]												
			17	/													
2 Jul	[redacted]	Diet: NPO after	05	/													
		Midnight	17	/													
2 Jul	[redacted]	Normal CPW pre-	05	[redacted]													
		cautions	17	/													
2 Jul	[redacted]	Splint to (R) leg	05	/													
			17	/													
2 Jul	[redacted]	Dressing to (L) hand	05	[redacted]													
			17	/													
03 Jul	[redacted]	VS Routine	08	/	[redacted]												
			12	/													
03 Jul	[redacted]	Regular diet	08	/	/	/	[redacted]										
			12	/	/												
			16	/	/												
03 Jul	[redacted]	~~UP OOB at will N~~ [redacted]	05	/	/	/											
		~~ON (R) leg~~ [redacted]	17	/	/												
6	[redacted]	up ad-lib ~~WWB~~	05	/	/	[redacted]											
		on (R) leg.	17	/	/												
9 July	[redacted]	~~Ortho Group A~~	18	/	/	/	/	/	/	/	/	/	[redacted]				
		dry dsg Δ QD															

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P I+D (L) Hand (R) foot
~~S/P GSW TO hand / (R) foot~~ i'd

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

PATIENT IDENTIFICATION:
2PW
[redacted]
b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 jun	[redacted]	Admit to WARD	1 jun	dn		[redacted]
1 jun	[redacted]	To OR in AM	2 jun	IN AM		
3/7	[redacted]	Resume previous orders S/P I&D	3/7/03	3/7		
	-----	(R) foot (L) hand condition stable				
5	[redacted]	Transfer to ICW2, Resume Previous Orders 5			1900	[redacted]
Kelly	[redacted]	NPO p lunch for washout today	Kelly	p 1200		[redacted]
Kelly	[redacted]	Transfer PACU → ICW2	Kelly	done	—	[redacted]
Kelly	[redacted]	Cond: Stable	Kelly	done	—	[redacted]
Kelly	[redacted]	Resume preop meds	Kelly	done	—	[redacted]
14	[redacted]	may DC to EPW camp	14	ASH		

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

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19
1 Jul	[redacted]	ancef 1 gm 980 EVPB	08					
			16					
			24					
			/					
3	[redacted]	Cipro 500 mg PO BID	08	[redacted]				
			20					
			/					
3	[redacted]	SL-flush QS	05	[redacted]				
			17					
			/					
14	[redacted]	tylenol 250 mg PO QID	06	[redacted]				
			12	[redacted]				
			18	[redacted]				
			24	[redacted]				
		b(6)-2						

DC'd 14 Jul 03

DC'd

DC'd 14 Jul 03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: SIP BSIC (L) hand/(R) foot
SIP IBD (L) hand/(R) foot

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 7 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
1.	[redacted]	phenergan 12.5mg														
- - - -	- - - - -	IVP q6° prn-nausea														
1.	[redacted]	Ambien 10mg PO														
- - - -	- - - - -	qhs-prn														
3.	[redacted]	percocet II-II PO														
- - - -	- - - - -	q4-6° prn-pain														
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															

USAPA V1.00

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
1 Jul	[redacted]	IVF: LR @ 100 ml	05	/	[redacted]	14		D/Ced				03	Jul	03			
			17	/								11	SST	[redacted]			
1 Jul	[redacted]	Ancef 1 gm Q 8°	08	/	[redacted]												
		IV	16	/													
			24	[redacted]													
03 Jul	[redacted]	Cipro 500mg	08	/	/	/	[redacted]										
		PO BID	20	/	/	[redacted]											
03 Jul	[redacted]	HL when taking	05	/	[redacted]												
		PO well	17	[redacted]													
03 Jul	[redacted]	IVLR @ 125 cc/hr Hep	05	/	/	[redacted]											
	[redacted]	Loc when tolerating	17	/	/												
		PO well	1														
			1														
14	[redacted]	Keflex 250mg PO	06	—	—	—	—	—	—	—	—	—	—	—	—	—	—
		QID	12	—	—	—	—	—	—	—	—	—	—	—	—	—	—
			18	—	—	—	—	—	—	—	—	—	—	—	—	—	—
			24	—	—	—	—	—	—	—	—	—	—	—	—	—	[redacted]

ALLERGIES: ☐ YES ☐ NO
MLDA

PRIMARY DIAGNOSIS:
s/p GSW to [illegible] foot Δ'd
PD I-D @ Hand [illegible] foot

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

PATIENT IDENTIFICATION:
2pw
#[redacted]
b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Jul Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7/3/03	[redacted]	#Saline Loc IV	7/3/03	Now	1600 03 Jul 03	[redacted]
		b(6)-2 AM				

Order/ Expir Date	Clerk/	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
23 Jul	[redacted]	MSO4 3-5 mg	0200 03 Jul 0800 4mg IV	0900 03 Jul 1300 4mg IV	1500 03 Jul 1900 4mg IV	2300 03 Jul 2200 4mg IV	3 Jul 1200 [redacted]			DCI 03 Jul 1602		23 Jul 03	1600		
		IVP q 3° prn	[redacted]												
2 Jul	[redacted]	Phenergan 12.5 mg	0000 03 Jul 0.5 IVP	2400 12.5 IVP	1200 03 Jul 2300 12.5 IVP	1200 03 Jul [redacted]									
		IVP q 6° prn nausea	[redacted]												
18 Jul	[redacted]	Ambien 10 mg PO													
		q HS prn													
3 Jul	[redacted]	Percocet 1/1 - 11/11 PO	0200 03 Jul 1600 1 PO	1200 03 Jul 0330 11/11	1900 03 Jul 1900 11/11	0100 03 Jul 2030 11/11 PO	7 Jul 2355 11/11	0300 03 Jul 0100 11/11 PO	0300 03 Jul 0141 11/11 PO						
		q 4-6° PRN pain	[redacted]												

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

95.4

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet — ICW2

OTSG APPROVED (Date)

Date: 09 JUL 03
Time In: 1455 9 JUL 03
Allergies: NKDA
Pre-op V/S: 90/60
Procedures: B & D with bone
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 0 EBL
Meds/Times: none given

90/60

Drains: ~~Hemovac~~ ~~NG~~ ~~JP~~ ~~T-tube~~ ~~Foley~~ ~~PCS~~

Airway: ~~Nasal~~ ~~Oral~~ ~~ETT~~ ~~Trach~~ ~~Other~~

Pre Op Meds 1455 — 1600 History

Time	1455	1456	1501	1506	1511	1516	1521	1525	1531	1536	1541	1545	1551	1556	1600
SaO2															
FiO2															
Methods															
240															
220															
200															
180															
160															
140															
120	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
100							✓							✓	
80	^	^								^		^			
60	•	•	^	^	^	^		^	^		^		•	•	
40			•	•	•	•	^	•		•	•	•	^	^	
20															
RR	22	14	14	14	15	14	15	16	18	14	17	12	12	20	
T	95.4								95.4		97.2				
Time															
Pain (0-10)															
LOS															

Pacu Intake

Time	Solution	Amount	Site	By	Infused
2/9/140	LR	KVO	L Arm	[redacted]	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1458 2	1427 2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	1	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] 91WMC b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 9 JUL 03

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

32 y/o 70 kg

b(6)-4

Dx, GSW (R) Foot infection (L) finger

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Hand	MOE	normal	+	<3 sec	warm	NRL
15'	Toe						
30'							
45'							
60'	Same as previous						
90'	Transferred to ICW & PER (II)						
D/C							

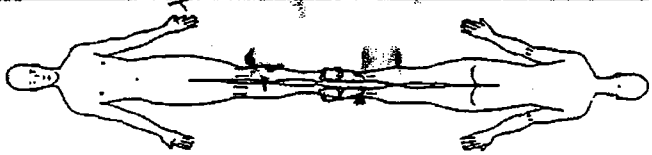
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Hand / (R) Foot	[illegible]	[illegible]
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1605	NDAB	NONE	0

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1553-1605	SR/SB	Ectopy	Continuous

WAMC OP 173-E

NURSING NOTES

received pt @ 1453 - VS recorded and [illegible] 5° dry on (L) hand (R) foot and MOE / <3 cap refill [illegible] palpable pulse on (R) foot dim & dry good cap refill < 3 sec good feeling in (L) foot & dry foot moved [illegible] [redacted] @ 1605 32416 EPW 379 [illegible] report to [illegible] [redacted] Neuro: Alert oriented PERRLA - 3-4mm MOE dry on (L) hand and (R) foot [illegible] pain medication given c/o discomfort when received meds pain level 5-6 on 10 point scale required medication reference [illegible] RR: 10-25 - CTA bilaterally GU normal [illegible] by urinary [illegible] [redacted]

blw - 2 AM

Discharge Criteria: 10 cm Scale
Date: [illegible] **Time:** 1605 **PARS:**
BP: 103/54 **T:** 97.2 **HR:** 72 **RR:** 25 **Sa02:** 100%
Pain Level at D/C (0-10): (5-6) [illegible] pain med required
Intake: 0 **Output:** 0
Additional Data: Dry on (L) hand (R) foot
Transferred To: ICW 2 Bed # 11
Report Given To: GOT [redacted]
Transferred Via: W/C, Litter, Gurney, Ambulance
Transferred [redacted]
Cleared IAW [redacted] SOP [redacted]
Charge Nurse Signature: [redacted]

120/71 58

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 7.12.03
Time In: 0825
Allergies: NKDA
Pre-op V/S: 120/71
Procedures: S/P Thoracotomy & Resection
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2000 KR Colloid
OR Output: UOP Ø EBL Ø
Meds/Times: 2.5 mg Versed 10 mg Versed

Pre Op Meds: History

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

Time	0825	0830	0835	0840
SaO2	97	99	100	100
FIO2	RA	RA	RA	RA
Methods				
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR	14	12	10	20
T	96.7			96.8
Time	0825	0835		
Pain (0-10)	Ø	Ø		
LOS				

59
95/61
97%
14
86.2
105/70
48
12
100%
109/69
53
10
100
107/72
57
20
00%
69

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
" = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

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

(Continue on reverse)

PREPARED BY (Signature & [redacted] b(4)-2 LT RN BSN
DEPARTMENT/SERVICE/CLINIC
DATE 7.12.03

PATIENT'S IDE[redacted] (Use this space to give: first, middle; grade; date; hospital or medical facility) Name – last.

E [redacted]
b(4)-4

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

TCW 2

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

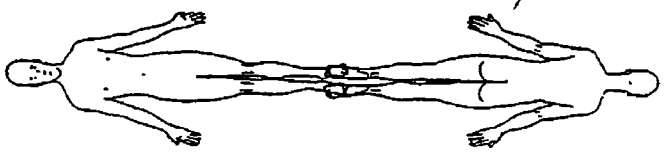
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	Abdomen	tubular	Ø
30'			Ø
60'			
D/C			Ø



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0830	SB	NSR & ectopy	

WAMC OP 173-E

NURSING NOTES

Pt arrived via litter, ∧ ett USS @ time of xfr from OR. Pt on RA Sp02 97-99%. Pt cooperative & follows all commands, able to move all extrem

A/O but confused, pt c/o 3cm sluggish

CV NSR S ectopy @ 130, +2 pulses radial & pedal bilat, all extrem warm cap refill <3secs.

Resp CTA bilat, breaths even & unlabored on RA @ 92% [illegible] @ cough.

GI abd soft nontender, ~~absent~~ BS decreased N/V/D.

GU @ foley @ UO.

Lines R wrist PIV

Discharge Criteria:
Date: 7/12 Time: 0855 PARS: 10
BP: 107/72 T: 96.9 HR: 50 RR: 12 Sa02: 100
Pain Level at D/C (0-10): Ø
Intake: Ø Output: Ø
Additional Data:
Transferred To: 7LW
Report Given To: SGT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: LCT [redacted] D(W)-2
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted]

Post-Anesthesia Care Unit (PACU) Flow Sheet

Date: 03Jul03
Time In: 1110
Allergies: NKDA
Pre-op V/S: 124/70 88
Procedures: I&D OF (R) FT (R) hand
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid
OR Output: UOP 0 EBL 0
Meds/Times: Morphine 10mg

Drains: Hemovac, NG, JP, T-tube, Foley, TLS — None

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1110	1120	1130	1135	1140	1155	1210
SaO2	99	96	92	95	96	95	97
FiO2							
Methods							
240							
220							
200							
180							
160							
140							
120	^	^	^	^	^	^	
100							
80	✓	✓	✓	✓	✓	✓	
60							
40							
20							
RR	17	12	10	14	14	16	
T	96.8		96.5				
Time							
Pain (0-10)							
LOS							

OR Intake

Time	Solution	Amount	Site	By	Infused
1115	LR	800cc	R FA	OR	800

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

AIRWAY: A = Ambu; BB = Blow-by; M = Mask; FT = Face Tent; RA = RoomAir; NC = Nasal Cannula

V/S: X = A-line BP; ^ = Cuff BP; • = Pulse

TEMP: S = Skin; O = Oral; A = Axillary; T = Tympanic; R = Rectal

LOS: C = Cervical; T = Thoracic; L = Lumbar; S = Sacral

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

(Continue on reverse)

PREPARED BY (Signature & Title): SGT [redacted] b(6)-4

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 03Jul03

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

EPW [redacted]
b(6)-4

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

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

MEDICATIONS

Allergies: NKDA

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	R Leg	F	NVI	+	b	96.8	pk
15'	"	F	NVI	+	b	96.2	pk
30'	"	F	NVI	+	b	97.2	pk
45'	"	F	NVI	+	b	—	pk
60'	"						
~~90'~~	"						
D/C	"						

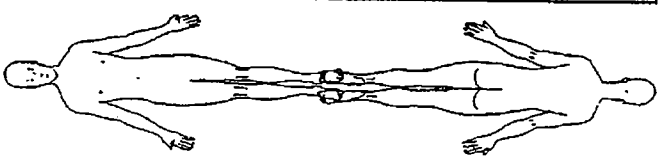
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Ft (L) hand	Kerlex/lace	Ø Ø
30'	" "	" "	Ø Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

314.0 EPW transferred via litter from OR to ICU 2 for ID + (R) Ft + (L) hand. VS 137/80 p 91 R 14 SaO2 96% RA. Color pk aroused c verbal + touch stimuli R-even unlabored NAD nasal airway (L) nare. pulses present cap refill brisk skin warm dry. IV (R) FA 18G 100cc/hr NSS patent (R) Ft Drg CDI cap refill brisk dec warm to touch. (L) hand drg CDI from NVI cap refill brisk will count to monitor SGT [redacted] 91WM6 — 1150 pt c/o inability to void had attempted to void x 10 min (+) DTN over syphis - in out cath 850cc clear yellow urine pt stated relief SGT [redacted] 91WM6 b(6)-2

1210 - VSS NAD LS CTA stated feels hungry Drg CDI X 2 SGT [redacted] 91WM6 —

b(6)-2

Discharge Criteria:
Date: 03 Jul 03 **Time:** 1210 **PARS:**
BP: 122/72 **T:** 98.2 **HR:** 74 **RR:** 14 **Sa02:** 96% RA
Pain Level at D/C (0-10): Ø
Intake: NPO (125cc NSS) **Output:** 750cc
Additional Data: Ø
Transferred To: Remained @ ICU 2
Report Given To: N/A
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: N/A

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 2-6-03
Time In: 0900
Allergies: NKDA
Pre-op V/S: 108/74-70
Procedures: I+D -(R) Foot/(L) Hand

OR Intake: Crystalloid 300 Colloid
OR Output: UOP EBL 0
Meds/Times:

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

14Kg

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time																		
SaO2	99	96	✓															
FiO2	RA																	
Methods																		
240																		
220																		
200																		
180																		
160																		
140																		
120	✓	✓	✓															
100																		
80																		
60																		
40																		
20																		
RR	20	16	20															
T	97.2																	
Time																		
Pain (0-10)																		
LOS																		

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

PREPARED [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC

DATE

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

Name – last,

#[redacted]

ICW-2 b(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

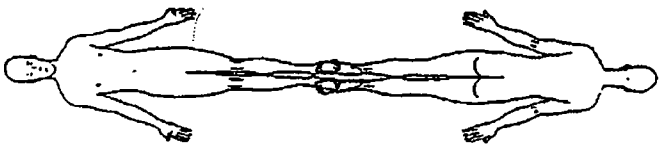
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

2046 - Rpt from CRNA [redacted]
2047 - Rpt Given to [redacted]

b(6) - 2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: **W/C** **Litter** **Gurney** **Ambulance**
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

b(6) - 2

1. L[redacted] | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUM[redacted] | CIALTY CODE / GPM | RELIGION / RE[redacted]

2. UNIT / U[redacted]

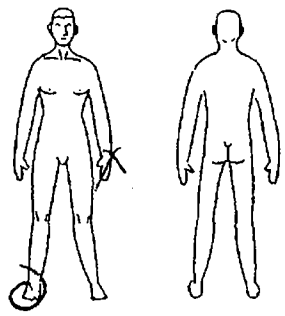
FORCE / ÉLEMENT | NATIONALITY / NATIONALITÉ

A/T | A/F/A | N/M | MC/M

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

GSW (R) Foot, L Hand amputation

EVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- ALERT / ALERTE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- VERBAL RESPONSE / RÉPONSE VERBALE
- UNRESPONSIVE / SANS RÉPONSE

ULSE / POULS | TIME / HEURE | 6. TOURNIQUET / GARROT NO / NON YES / OUI | TIME / HEURE

MORPHINE / MORPHINE NO / NON YES / OUI | DOSE / DOSE 10mg | TIME / HEURE 2215 | 8. IV / IV | TIME / HEURE

TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS · PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

I.V 18GA (D) AC D.9% Saline @ 2145

1 Gram Ancef @ 2150

Bag H2 LR @ 2205

10. DISPOSITION / DISPOSITION
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ | DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 — This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD) 1 Jul 03 | TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE	2200			
BP / PS	122/78			
PULSE / POULS	73			
RESP / RESP	20			

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

15. PROVIDER / OFFICIER MÉDICALE | DATE/DATE (YYMMDD)

16. DISPOSITION / DISPOSITION
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

[redacted]ICES / [redacted]UX
- BAPTISM / BAPTISÉ
- ANOINTING / ONCTION
- CONFESSION / CONFESSION
- PRAYER / PRIÈRE
- COMMUNION / COMMU[redacted]
- OTHER / AUTRE

CHAPLAIN / CHAPELAIN

MEDCOM - 12675

ADMISSION A[illegible] CODING INFORMATION

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

1. REPORTING MTF							TF LOCATION (State or Country Code.)
1	2	3	4	5	6	/	8
A	1	1	D	1		1	Z

3. REGISTER NUMBER						
9	10	11	12	13	14	15
[redacted]						

NAME (~~Last, First, Middle Initial~~) b(4)-4

EPW [redacted]

4. PAY GRADE	
16	17

5. SEX
18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)							
19	20	21	22	23	24	25	26
1	9	7	1	0	1	0	1

7. AGE AT ADMISSION		
27	28	29
3	2	y

8. RACE	
30	
Z	

9. ETHNIC BACK-GROUND	
31	
9	

RELIGION: unk

10. LENGTH OF SERVICE		
32	33	34

ETS: N/A

11. FMP	
35	36
9	9

12. SOCIAL SECURITY NUMBER								
37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only): N/A

13. MARITAL STATUS	
46	
U	

HOUR OF ADMISSION: 2323

BRANCH / CORPS: N/A b(4)-4

14. FLYING STATUS		
47	48	49

15. BENEFICIARY CATEGORY		
50	51	52
K	7	9

16. ZIP CODE OF RESIDENCE								
53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)	
62	63

18. MOS						
64	65	66	67	68	69	70

19. TRAUMA
71

PREV. ADMISSION: YEAR [ ] [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
72
Ø

WARD: ICU2

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b2-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	
73	74
5	Ø

22. MTF TRANSFERRED TO					
75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y M M D D)					
81	82	83	84	85	86
Ø	3	Ø	7	1	4

24. CLINIC SVC - ADMITTING			
87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM					
91	92	93	94	95	96

26. DATE THIS ADMISSION (Y Y M M D D)					
97	98	99	100	101	102
Ø	3	Ø	7	Ø	1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
103	104

28. MTF OF INITIAL ADMISSION					
105	106	107	108	109	110

29. DATE INITIAL ADMISSION (Y Y M M D D)					
111	112	113	114	115	116

FOR LOCAL USE

Dx: S/P GSW to (L) hand + (R) foot
S/P I+D (L) hand + (R) foot

Injury Trauma
450 1

Dx: 9583
6827
V5849
E9440

Pr: 8604

ADM[redacted]ired) [redacted] R CPM

Dx [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted] PFC, 91G18

b(4)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGIS[redacted]			2. N[redacted] First MI [redacted] EPW# [redacted] b(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 27	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION —		14. WARD ICU3	
15. FLYING STATUS —	16. RATING/DSG —		17. DEPT./BEN K78	18. BRANCH/CORPS b(4)-4	19. UIC/ZIP —	20. TYPE CASE WIA	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION: 2330	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk	25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 6 Aug 03	b(6)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk	27b. TELEPHONE NO.: unk	28. DATE OF THIS ADMISSION: 13 July 03	ADMITTING OFFICER: DR [redacted]
29. [redacted] b(2)-2		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (R) tibia w/fix, GSW to (R) hand

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	26	26

36. Total Days All Facilites

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

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

DA FORM [redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

b(4)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]	2. NAME (Last, First, M) EPW# [redacted]				3. GRADE EPW	ADMISSION REMARKS
4. SEX M / AGE 27	6. —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION b(4)-2		14. WARD ICU3	
15. FLYING STATUS —	16. RATING/DSG —	17. BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION: 2330	23. CLINIC SERVICE: AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: Unk			25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 13JUL03		b(4)-2
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK			27b. TELEPHONE NO.: Unk	28. DATE OF THIS ADMISSION: 02JUL03		ADMITTING OFFICER: DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (R) Tibia ext-fix, GSW to (L) hand

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	12	12

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	b(4)-2	[redacted]			

SIGNATURE OF ATTENDING MEDICAL OFFICER: DR [redacted]

SIGN[redacted]R MEDICAL RECORDS OFFICER: [redacted]

MEDCOM - 12678

DA FORM [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

24 YO ♂ s/p GSW to (L) hand and (R) LLE – x 2 days ago. Now (L) ~~[illegible]~~ HYPO thenar eminence numbness and (R) foot x 1 [illegible]

Ø meds

Ø NKDA

PHYSICAL EXAMINATION

NAD
ST/NL heart
CVA/T – ST
Ext – (L) hand – contusion (L) CB with wound over hypothenar eminence
(R) foot – large, swollen, open wound with exposed bone

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

(P) I&D in OR.

b(6)-2

SIGNATURE OF PH[redacted]	DATE 1 Jan 03	IDENTIFICATION NO.	ORGANIZATION

PATIENT IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
[redacted]		

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

b(4)-4

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1 July 03	
	(S) PT ↗ & (R) Tibia Fixation & (L) hand GSW
Pulse 95	PT in hospital 6 days out 10 days w/o treatment
BP 118/62	no meds/antibiotics. PT states he can feel foot
RR 18	on scale 8/10 A&O x 3.
Temp 99.3	
	(O) 6 inch avulsion (R) tibia, 2 sutures.
	3 inch GSW (R) fibia, entry 2 sutures
	(+) edema, (+) weeping D/C, green pus (+) infection.
meds	Tissue and Bone visible gangelia (R) toes
none-	(-) Pulse dorsal pedis
	(L) hand GSW 2 inches 3 sutures. cap refill 3 sec.
	radial pulse present,
	Pt cannot extend the 5th Distal phalange
	(A) GSW, left hand right leg
	(P) 1. I.V. Lactated Ringer's
	2. Povidine Scrub, Hydrogen Peroxide Cleaning
	3. Tylenol 3 P.O. (2) 2030 hrs
	4 External Fixater was cleaned
	5 Wet → Dry Dressing
	6 SBI1st → CSH

b(4)-2

[redacted]

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

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

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

[redacted]

b(4)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | ~~CHRONOLOGICAL RECORD OF MEDICAL~~ CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
~~Aug~~ Jul 2003 @0100	Admission – Pt is 27 y/o EPW male. S/P GSW to (R) Tibia c̄ external fixator and GSW to (L) hand c̄ dressing. Admitted to ICU #3 via EMT. Vital signs upon arrival stable. IV access in (R) forearm 18g cath c̄ LR @ 125 cc/hr. Pt restrained at 2 points (L) arm and (R) leg. Scheduled for OR later in AM. Pt currently NPO. Will continue to monitor. [redacted] b(6)-2 SPC 91WM6
@0200	Pt c/o inability to urinate. Upon assessment pt's bladder was firm upon palpation. 16 fr. foley cath placed which yeilded 1100 cc of clear yellow urine. Pt communicated cath produced relief. Will continue to monitor. [redacted] 91WM6 SPC
@0412	PT c/o pain to RLE @ external fixator 4 mg MSO4 given. Will continue to monitor [redacted] 91WM6 SPC
@0500	Report given to LTC [redacted] Pt VSS afebrile. [redacted] SPC 91WM6
2 Jul 03 0600	Received pt this am w/ plan for OR. V.S. [redacted]. Pt resting quietly. See initial assessment note. (R) LE w/ external fixator. Cap. refill + pulse to (R) foot palpable but faint (< 3 secs.). (R) noted to have black on areas to toes. Area of 1" by 3" on top of (R) foot looks like a blood vessels but

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.

EPW [redacted]

b(6) -4

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

#1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	hardened. Quarter-size skin break down on outer lateral aspect of (R) foot. (R) foot appears to have been burned in area of skin-break down. Cont. to monitor. Pain management. - [redacted] LTC/AN
2 Jul 03 1600	Pt continues to be NPO. Awaiting OR for (R) tibia Fx. MSO4 IV given as ordered. Pt concerned w/ brother who came in w/him. Plan: IVF, OR, Pain management. - [redacted] LTC/AN b(6)-2
3 Jul 03 0515	Received report and care of pt. from night shift. Pt resting in bed & s/s of pain/discomfort. Pt currently NPO awaiting to go to OR. VSS will cont to monitor — b(6)-2 [redacted] LPN
1000	Pt continues to be NPO awaiting OR. Pt resting comfortably. & s/s pain discomfort. will cont to monitor — [redacted] LPN b(6)-2
3 Jul 03	ONLOAD OF NOTE
	Pre Op Dx - (1) Open fracture III B (R) tibia fx. (2) Open (L) SF ML FX
	Post Op Dx - same
	Procedure (1) I+D (R) LLE
	(2) I+D (L) Hand
	Surgeon - [redacted] b(6)-2
	Anes - [redacted] 980 hr
	Findings - large thrombus + thrombus BSV with large SCM tissue defect, dead bone in wound, bad clean
	Plan: BKA. [redacted] b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

NSN 7540-00-434-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1530	Pt rcvd 90 [redacted], 20 mg, 0.4, 50 mg Benadryl, 2.5 mg Versed UOP 200cc, PT now resting in bed & s/s of pain/discomfort.
1700	Report + care of pt
1700	Received report from day shift. Pt appears to be resting comfortably in bed. Foley draining to gravity, urine clear & yellow. External Fixator to (R) Lower Extremity. Dressing C/D/I. Will continue to monitor [redacted]
2100	Pt appears to be sleeping comfortably VSS, Continue pain management. Will continue to monitor [redacted] SPC, 9/WM
0100	Pt appears to be sleeping comfortably, continue pain management. VSS Will continue to monitor [redacted] SPC, 9/WM6
0500	Gave report to day shift [redacted] SPC, 9/WM
0515	Received report and care of patient from previous shift. pt sleeping and shows ∅ s/s of pain/discomfort. VSS Will cont to monitor [redacted] PN
0900	Pt resting in bed & C/O pain/discomfort. VSS Will cont. to monitor [redacted] PN
1030	Pt C/O pain to (R) Lower extremity. Pt given 2 tabs

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	b(6)-2

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.

All

EPW # [redacted]

b(6)-4

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

#2

b(6)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	percocet for pain. will cont to monitor — [redacted] PW
1430	Pt resting in bed & c/o pain/discomfort. Pt consumed 1/3 lunch and drank 1/2 lit water. VSS will cont to monitor — [redacted]
1700	Pt received 2 tabs percocet for pain. Pt resting in bed. Report and care of pt. given to on-coming [redacted] shift — [redacted]
1730	Report recieved from spc. [redacted] pt VSS will continue to monitor. — [redacted] 9/WM6
2400	Pt sleeping in bed. VSS — [redacted] 9/WM6
5Jul03	Received report from previous nurse. VSS will continue
0600	to monitor. — [redacted]
0800	Dr [redacted] in ō interpreter to discuss plan of care: amputation, risks, benefits and alternatives [redacted]
1000	pt's brother from IW, here to talk to him. [redacted]
1730	Report recieved from SPC [redacted] VSS, surgery rescheduled for tomorrow. pt ate dinner, will be NPO @ midnight. Will continue to monitor — [redacted] 9/WM6
2400	Pt VSS afebrile. NPO for surgery in AM. Will continue to monitor — [redacted] 9/WM6
0500	Report given to PFC [redacted] — [redacted] 9/WM6
0535	pt Report Recieved From spc [redacted] VSS no problems @ presen pt awaiting procedure. will continue to monitor — [redacted] RC 9/WM
1200	pt resting in bed complains of pain in R LE. Pt medicated per elevation orders — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 Jul 03	SURGERY PT POD#1 BKA – LEFT OPEN 2° TO CONCERNS OF INFECTION. CNS: AWAKE ALERT CVS: RASR HR 80s BP 120/70 LUNGS: CTA 95% RA WOUND: DRESSING CLEAN, DRY & INTACT LABS: 11.9 / 11 / 35 < 876 Rp: SMASH POD#1 PLAN TO OR TOMORROW TO CLOSE STUMP NPO @ MIDNIGHT Hep-lock IV [redacted] b(6)-2
9 Jul 03	SURGERY PT POD#2 CLOSURE OF RIGHT BKA STUMP. PT C NAUSEA & EMESIS THIS AM @ POUR CNS: AWAKE & ALERT CVS: HR ~100 BP 130/55 17.8 / 27.3 <MM LUNGS: CTA 95% RA CVS: ↓ INTERMITTENT ABD: SOFT, NTND @ BS STUMP: PAIN CONTROLLED Imp: POD#2 ↑ WBC & POUR UNKNOWN ETIOLOGY. PLAN: NO LAXATIVES – Foley OUT MONITOR [redacted] b(6)-2

b(6)-2 All unless marked otherwise

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6July03 1945	Pt back to ICU 3 from OR. S/P (R) BKA. Recovery performed in ICU 3. see Pacu form for detials. Pt A+O x3 moves all four extremities. Dressing to (R) leg C̄ ace wrap. Ø drainage at surgical site. IV LR@ 50 cc/hr. Fentanyl @ 175 mcg/hr for pain. Will continue to monitor. [redacted] 9/WMC
2200	pt resting in bed. VSS, afebrile. c/o pain to surgical site will notify MD [redacted] 9/WMC
2300	Order for Versed obtained from Dr. [redacted] 4 mg given. Will continue to monitor [redacted] 9/WMC
7 0200	pt resting comfortably. VSS Fentanyl drip at 150 mcg/hr. [redacted] 9/WMC
0755	pt Report Recieved From Spc [redacted] VSS pt resting calmly in bed @ this time no [redacted] problems noted @ present will continue to monitor [redacted] RPC 9/WMC

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

EPW # [redacted]

b(6)-4

RECORDS MAINTAINED AT:

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7Jul03@	Recieved report from off-going shift. Pt awake in bed. A+O×3. Pt c̄ Fentanyl drip
1715	@ 150 mcg/hr. Pt states still has pain from time to time. Pt given 2.5 mg Versed for agitation/phantom pain. Pt's tegument hang. VSS. Pt's (R) LE elevated on pillow. Drag on stump COT. Will continue to monitor — [redacted] EPN
2100	Pt resting quietly. No c/o pain @ this time. Interpreter in to see pt and explained to pt that he is to be NPO p̄ MN for OR tomorrow. VSS. Will continue to monitor. — [redacted] EPN
0100	Pt NPO since MN for OR in AM. LR started @ 100cc/hr as per MD's orders. Pt's VSS. Pt given 2.5 mg Versed and Fentanyl ↑ to 175 mcg/hr. Pt c̄ adequate pain control @ this time. Will continue to monitor [redacted] EPN
0430	Pt rested mostly throughout night. Pt had periods of worse pain @ times. Pt on 175 mcg Fentanyl/hr – 150 mcg/hr Fentanyl throughout night. Pt given 50-100 mcg boluses after times for worsening pain. Pt given Versed ×3, 2.5 mg for agitation. Pt NPO since MN and LR @ 100 cc/hr started @ MN as well. Pt's VS remained stable throughout the night c̄ QS urine output. Will pass report to day shift. [redacted] EPN
@0500	Recieved report from spc [redacted] pt resting quietly in bed @ this time awaiting OR for procedure — [redacted]
@ 1120	Pt back from OR. New orders written and transcribed. Pt doing well. No problems @ present. Will continue to monitor
@	— [redacted] SPMMC

b(6)-2 ↑ All

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

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

EPN [redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

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

b(w)-2 A1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
08 Jul 03 @ 1925	pt ↑ temp to 103.4 pt given tylenol will recheck Temp in 1° and monitor for further complications now @ present will continue to monitor — [redacted] PFC Gwen
8 July @ 1730	Report recieved from PFC [redacted] pt VSS Will continue to monitor. — [redacted] 9/WMG
@ 2000	pt temp ↑ 101.1 Tylenol 650 given [redacted] 9/WMG
@ 2400	pt resting in bed. VSS — [redacted]
@ 0400	pt sleeping, AM labs drawn, VSS Fentanyl gtt @ 175 mcg/hr — [redacted]
09 Jul	
0500	Received report + assumed care of pt. VSS, Pt lying in bed + appears to be resting comfortably @ this time. Will continue to monitor. — [redacted] 9/WM
0800	Pt lying in bed sleeping + appears to be resting comfortably @ this time. Will continue to monitor. [redacted] 9/WMG
0805	Fentanyl ↓ from 175mcg to 150mcg, Pt lying in bed c̄ ∅ ntl complaints. Will continue to monitor. — [redacted] 9/WM
1000	Fentanyl ↓ from 150 mcg to 100 mcg. Pt lying in bed + appears to be resting comfortably @ this time. Will continue to monitor. — [redacted] 9/WMG
1200	Pt received 1 liter LR bolus for low urine output. Will continue to monitor. — [redacted] 9/WM
1300	Fentanyl ↓ from 100 mcg to 50mcg. Will continue to monitor. — [redacted] 9/WMG
1330	Pt complaining of pain, medicated c̄ 2mg MSO4. Will continue to monitor. — [redacted] 9/WMG

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STANDARD FORM 600 (REV. 6-97) BACK

09 Jul

NOTES

b(6)-2

1530 Pt urinated, 1075 cc clr yellow urine obtained. Urn sent to lab. Pt now lying in bed & appears to be resting comfortably, will continue to monitor. — [redacted] 9/WMG

1200 Report given to Nightshift. — [redacted] 9/WMG

1730 Report recieved from SPC [redacted] Pt VSS, afebrile Fentanyl drip @ 50 mcg/hr. NS @ 50 cc/hr. Will continue to monitor — [redacted] b(6)-2 9/WMG

1900 Fentanyl drip D/C'D — [redacted] 9/WMG

2200 Pt resting comfortably in bed. VSS temp 100.3 will continue to monitor. — [redacted]

0300 Pt sleeping Ø c/o pain @ this time [redacted]

10 July

0500 Received report & assumed care of Pt. VSS, Pt lying in bed sleeping & appears to be resting comfortably @ this time. Will continue to monitor. — [redacted] 9/WMG

0700 Pt sitting ↑ in bed eating breakfast c̄ Ø ntd complaints @ this time. — [redacted] 9/WMG

0900 1 Liter LR bolus given per order. Pt appears to be resting comfortably. Will monitor. — [redacted] 9/WMG

1045 Pt lying in bed sleeping c̄ covers pulled over head. Appears to be resting comfortably @ this time. — [redacted] 9/WMG

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

AUTHORIZED FOR LOCAL REPRODUCT

:AL RECORD | PROGRESS NOTES

:E	NOTES
10 July	b(6)-2 All
1100	Pt complaining of pain, medicated c̄ 2 tabs Percocet. Will continue to Monitor. — [redacted] 9/WMG
1300	Pt Lying in bed sleeping & appears to be resting comfortably @ this time. Will continue to Monitor. — [redacted] 9/WMG
1700	Gave report to Nightshift.
10 July (1700)	Pt care Report Recieved from S[redacted] Pt awake, alert, oriented s̄ acute episodes noted. — [redacted] 9/WMG
10 July (2100)	Percocet tab ii PO given for c/o stump discomfort @ distal end & at anterior knee. Pt quiet p̄ care. [redacted] 9/WMG
10 July 03 (0330)	Percocet tab ii PO given for c/o stump discomfort. Quiet p̄ care. [redacted] 9/WMG
11 July 03 (0430)	Pt Remain asleep s̄ acute Episodes noted — [redacted] 9/WMG
11 July (0500)	PT Care Report given to SFC [redacted] Pt Resting quietly s̄ acute Episodes noted. — [redacted] 9/WMG

11 July 03 @ 0620 pt report recieved from SSg [redacted] USS Assessment complete WNL See pt Flowsheet pt resting quietly in bed pt c/o pain medicated (cont)

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

#[redacted]

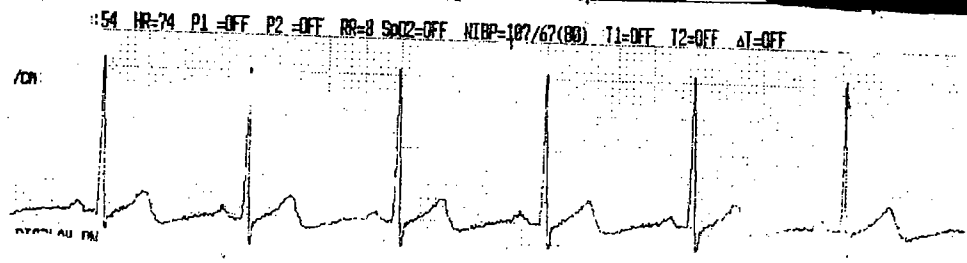
b(6)-4

PROGRESS NOTES
Medical Record

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

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
	b(6)-2 A1
11July03	(cont) per doctors orders no other problem noted @ present will continue to monitor — [redacted] PFC 9/WMG
11July03	@ 1130 pt cast removed c̄ c/o pain medicated per doctors orders pt rested after procedure pt up out of bed to comode c̄ little assistance will continue to monitor — [redacted] PFC 9/WMG
11July03	@ 1310 pt taken to OR for procedure will continue to monitor upon return — [redacted] PFC 9/WMG
11July03	@ 1520 pt returned [redacted] from OR @ 1415 new orders written pt VSS x̄ Temp of 100.7 ~~and~~ pt complains of pain medicated per doctors orders no other problems noted @ present will continue to monitor — [redacted] PFC 9/WMG
11July03	(1700) Pt care report Recieves from [redacted] PFC
b(6)-2	[redacted] Pt s/p surgical procedure, s̄ acute Exacerbate noted / Reported. — [redacted] 9/WMG



11July03	(2000) Initial dose of vancomycin 500mg IVPB given per dr order s̄ incident. Fentanyl drip on hold during Antibiotic infusion. Pt resting quiet @ present. — [redacted] 1/WMG
11July03	(2130) 15mg fentanyl IVP given by Maj.
b(6)-2	[redacted] 2° c/o break thru discomfort. Quiet c̄ care. Initial dose of Flagyl 250mg IVP given per dr order s̄ incident. — [redacted] 9/WMG

b(6)-2

EPW [redacted]

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 Jul 03	SURGERY PROGRESS
	PT STABLE POD #2 PAIN WELL CONTROLLED
	VSS / AFOB
	LUNGS: CTA
	ABD: SOFT, NT, + BS
	CAST IN PLACE
	LABS 13.6 (101) 6 (144) 14.9 / 26 (465) 3.9 (25) .4
	IMP: STABLE
	PLAN: TRANSFER TO ICW
	SEE ORDERS [redacted] b(6)-2
11 Jul 03	SURGERY OF NOTE
	PRE-OP DX: INFECTED STUMP
	POST-OP DX: INFECTED STUMP & ANEMIC BOWEL
	PROC: I+D & WASH-OUT
	F/U: 600 cc LR STABLE TO ICW
	EBL: MIN WOUND [redacted]
	UO: NA SEE [redacted] b(6)-2
	COMPLICATION: Ø

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1O)
USAPA V1.00

b(6)-2 A1
unless noted otherwise

AUTHORIZED FOR LOCAL REPRODUCT

:AL RECORD | PROGRESS NOTES

NOTES

11 July 03 (2200) Fentanyl drip discontinued ~~s~~ incidents. Pt given Routine med of IVP toradol 30mg by Maj [redacted]. VSS. afebrile. Stump dressing intact ~~s~~ new drainage noted. — PIV (R) FA patent ~~s~~ S/Sx infiltration. Pt re-positioned. independent movement ~~c~~ verbal instruction. Stump ↑ on blankets rolls. [redacted] GWMC

11 July (2315) Pt care report given to SPC [redacted]. Pt Rest. q quietly ~~s~~ acute episode noted. — [redacted] GWMC

12 July 0010 Pt resting quietly in bed. A+Ox3 but drowsy. Pt NPO p̄ MN for OR in AM. Pt expresses no needs @ this time. Will continue to monitor. — [redacted]

12 July 03 Pt continue to c/o (R) stump pain, increased Fentanyl drip
0230 to 150mcg/hr. voiding spontaneously 950cc each time. Gave MSO4 3mg in addition to the ↑ rate of Fentanyl. Monitor effect titrate Fentanyl drip as needed to maintain comfort [redacted] GWMC

0430 Pt c/o pain off and on throughout night. Pt's Fentanyl drip titrated to effect. Pt has been NPO p̄ MN for OR today. Pt supposed to go to OR @ 0530 for wound/stump debridement and washing. Ace wrap on stump CDI. No more drainage noted since beginning of shift. Pt given 0400 dose of Toradol by Maj [redacted] @ 0345. Will pass report to oncoming shift. — [redacted] LPN

SHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | (SSN or Other)

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

EPW
[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
12 July 03 0500	Recieved report from Spc. [redacted] Pt. resting c̄ eyes closed, easily aroused. ∅ distress noted. Resp 14. Will continue to monitor. — Sgt [redacted]
0523	Resting in bed c̄ eyes ~~closed~~ emm opened. VSS stable. ∅ complaints voiced. Drsg noted to @ ~~stump~~ emm amputated leg c̄ moderated amount of old drainage noted to drsg. Will continue to monitor. — Sgt [redacted]
0542	Anesthetist here to pre-medicate pt. for OR procedure. — [redacted]

Surgery op-note

pre-op dx: infected @ BKA stump

proc: dressing & washout

surg: [redacted]

complications: ∅

EBL: 200cc

Fluids: 2000cc

b(6)-2+11

UO: NA

Drains: none

Stable to PCU

Report recorded in A.M

[redacted]

0650 Return from OR. c̄ distress. BP 103/66 Pulse 79 RR 11 SpO2 100% O2C 6L/50%. Recieved 2mg versed, 70 of Propofol 20mg of [redacted] Stump dressed. Will monitor. — Sgt [redacted]

b(6)-2 A1
unless noted dif.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 July 03	Stump dressg reinforced @ this time. — [redacted]
0710	BP 108/74, HR 101, RR 13, SpO2 100%. — [redacted]
@0900 2Jul03	IV restarted in [redacted] forearm with a 20G catheter. Antibiotic + LR infusing ~ difficulties. Pt voices ∅ c/o c this time. [redacted] LTC/A1
1108	Pt resting quietly ~ distress. ∅ complaints voiced at present time. Will cont. to monitor. — [redacted]
1309	c/o stump pain. Percocet Tab # po given for c/o pain. Will continue to monitor. — [redacted]
1348	Continue to c/o stump pain. MSO4 4mg IV given for c/o pain. Will continue to monitor. — [redacted]
1514	Resting in bed ~ complaints. Will continue to monitor. [redacted]
1535	c/o stump pain @ present time. MSO4 4mg IV given for [redacted] pain. Will continue to monitor. — [redacted]
1611	∅ complaint voiced @ present time. Will continue monitor. — [redacted]
1730	Report recieved from SGT [redacted] pt vss. LR @ 125 into ⓡ arm IV. Wash out done in OR today to ⓡ stump. pt resting quietly [redacted] 91WM6

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

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

REGISTER NO. | WARD NO.

EPW # [redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2
A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 July 03 2130	Pt sleeping comfortably in bed. UOP adequate. Will continue to monitor — [redacted] 9/WM6 SPC
0200	Pt resting quietly in bed. VSS afebrile. Will continue to monitor — [redacted] 9/WM6 SPC
0450	pt sleeping in bed. VSS, afebrile. AM labs drawn. WBC 6.7, RBC 2.85, Hgb 7.7, Hct 25.2 pt for OR this am. No significant changes in condition during night shift. [redacted] 9/WM6 SPC
0552	Recieve report from Spc. [redacted] Ø complaints. Ø distress noted @ present time. Will monitor. — [redacted]
0643	C/O [redacted] abd. pain. Attempt x1 to go to bedside toilet unable @ time. Will monitor pt. for distress. SpO2 100% HR 74. — [redacted]
0737	C/O Stump pain. MSO4 4mg IV given for C/O pain — [redacted]
0900	Return from OR. Condition remain stable. Received 250mg Fent., 2.5mg versed & 180mg of Propofol. C/O Stump pain 4mg of MSO4 IV given for C/O. Will monitor — [redacted]
0924	Percocet Tab ii po given for C/O Stump pain. Fent ↑ to 25 cc/hr. Will continue to monitor. — [redacted]
0946	Medicated per MD order via LtCol [redacted] Will monitor. B/P 118/67 HR 79 RR 8 SpO2 91. Ø distress noted. Condition Stable. — [redacted]

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

b(6)-2 A7) unless otherwise noted

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03 0945	Pt. resting c̄ eyes closed. RR 6 SpO2 95%. HR 66. Ø complaints. Ø distress. Will continue to monitor. Sgt [redacted]
1100	Pt. resting quietly ō complaints. BP 117/69 RR 9 SpO2 99 HR 71. Will continue to monitor. — Sgt [redacted]
1149	C/o pain Percocet 5/325 ii po given for complaint. Sgt [redacted]
1220	Continue to c/o pain. MSO4 4mg given IV for c/o pain. Will monitor. — Sgt [redacted]
1254	Resting c̄ eyes closed. Easily aroused. Will continue to monitor. — Sgt [redacted]
1401	Pt. up to bedside toilet washing self. Ø distress. Ø complaints voiced. Will continue to monitor. — Sgt [redacted]
1435	C/o Stump pain. MSO4 4mg IV given for complaint. Sgt [redacted]
1600	Lying in bed c̄ eyes opened. Ø distress noted. Ø complaints voiced. Will continue to monitor. — [redacted]
1650	C/o Stump pain MSO4 4mg IV given for complaint. Will continue to monitor. — Sgt [redacted]
1730	Report recieved from SGT [redacted] pt VSS IV Fluids LR @ 125 cc/hr. Fentanyl drip @ 100 mg/hr pt interacts well with staff. Will continue to monitor. — [redacted] 9/[redacted]6

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

EPW # [redacted]

b(6)-4

RECORDS MAINTAINED AT: ▶

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

OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3July03 2300	pt sleeping at this time. VSS stable. Ø c/o pain @ this time. Will continue to monitor [redacted] 91WM6
@ 0120	pt had an episode of nausea and vomited approx. 200cc fluid. pt stated nausea passed after emisis. Will continue to monitor [redacted] 91WM
@ 0300	pt AM labs drawn. Hgb 7.0, Hct 22.6 Dr. [redacted] notified. pt cross matched for 2 units PRBC's. [redacted] 91WM6 SPC
@ 0500	pt VSS, currently sleeping on call for OR today [redacted] 91WM6 SPC
0530	Received report from Spc [redacted] Pt. alert & responsive
4July03	this am. c/o pain to stump, 2mg MSO4 IV given for complaint. Drainage noted to ace wrap on stump. Pt. NPO this am for OR procedure. H&H low. Typed & screened for PRBC. Will monitor pt. for S/Sx of distress. [redacted]
0800	Resting in bed c̄ eyes closed. Ø complaints voiced @ present time. Ø distress noted. Will monitor for S/Sx of distress. [redacted]
0846	c/o stump pain 4mg MSO4 IV given as Rx. Will continue to monitor. [redacted]
0950	MSO4 4mg IV given for c/o stump pain. Will continue to monitor. [redacted]
1132	Resting c̄ eyes closed. Ø distress noted. Resp 12. Will continue to monitor for S/Sx of distress. [redacted]
1334	Resting c̄ eyes closed. RR 22. Ø distress noted @ present time. Will continue to monitor. [redacted]
1604	Resting in bed c̄ complaints @ present time. Will continue to monitor for S/Sx of distress. [redacted]

*U.S. Government Printing Office: 1995 — 387-722/20035

b(6)-2 A11

STANDARD FORM 600 BACK (REV. 5-84)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

13 July 03 Procedure Note
Pre Dx: Infected BKA
Post Dx - SAME
Procedure - Wound out BKA
Surg
Surgeon [redacted] b(6)-2
Anesthesia [redacted]
Findings Pressure sore (P) probable
vessel but pulsatile good.
No devitalized tissue

Cycle ↓
To Recovery

[redacted] b(6)-2

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

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

[redacted] b(6)-4

REGISTER NO.	WARD NO.

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

NSN 7540-00-634

DICAL RECORD

NURSING N
(Sign all not

TE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 July 03		1800	Received report from ongoing shift. Pt scheduled to OR remain NPO, pt aware. Fentanyl drip in progress titrate to effect, appear comfortable in bed. [redacted] VSS, BP↓ Map 70. LR @ 125 cc/hr. H+H 7/22.0 MD made aware from previous shift. Continue POC as planned. [redacted] May 1 Am b(6)-2

See next page

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 Jul 03	OP NOTE
	PRE-OP DX: INFECTED (R) BKA STUMP
	POST-OP DX: SAME
	PROCEDURE: DEBRIDEMENT OF KNEE & WASH-OUT OF STUMP
	SURGEON: [redacted] b(6)-2
	ANESTH: GETA
	EBL: minimal
	FLUIDS: b(6)-2
	VO: NA
	STABLE TO ICU [redacted]
14 July 03 1945	Post-procedural note
	Returned from the OR S/P washout, pt drowsy but easily aroused. Minimal EBL received 1500cc 20mg ē Propofol 200 mg ē induction anesthetic. PICC line placement (R) AC dressed ē aptic on arrival. Resume previous orders as noted. VS: 98.7 90-13-100/51-99% RA. Resting comfortably in bed. [redacted] Maj/Am
2045	IVF transferred to (L) AC PICC line. Fentanyl @ 100 mcg/hr, UR @ 125. site started today in the OR [redacted] Maj/Am

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.

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 July 03	Pt slept most of the night, on Fentanyl 100 mcg/hr.
0400	Pain well controlled. PICC line intact c̄ LRC 125 cc/hr
	VSS — [redacted]
0430	Fentanyl decreased to 50 mcg/hr to awaken pt. needed
	to void. NPO p̄ MN to OR this AM — [redacted] Thy/RN
0545	Received report from Nightshift & Assumed care of Pt.
	VSS, will contine to Monitor. — [redacted] AWMG
0615	See Assessment sheet for Assessment — [redacted] AWMG
0630	Pt ↑ OOB to BSC — [redacted] AWMG
0730	Pt picked up for OR. — [redacted] AWMG
15 JUL 03	OR NOTES
	Pre-op Dx: Infected (R) BKA stump c̄ necrosis
	necrosis of Right pre-patellar skin
	Proc: Washout & debridement - closed skin over
	patella
	Surg: [redacted]
	EBL: 200cc b(4)-2 A11
	Fluid: 200cc Hespan 400cc LR
	UO: NA
	Complications: Ø
	Stable to ICU
	[redacted]
1000	Pt Lying in bed c̄ Ø Ntd ~~c/o pain @ this time~~ Complaints
	@ this time. Pain being controlled. — [redacted] AWMG
1200	Preparing for blood trasfasion. — [redacted] AWMG

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

15 Jul 03 1215 First unit PRBC's started @ this time. Blood verified + Pre-transfusion vitals obtained. Will monitor. — [redacted] 9/6/06

b(6)-2

Time	1210	1215	1220	1225	1230	1235	1250	1305	1330
BP	97/50	100/44	101/48	99/54	104/58	105/55			
Temp	98.5	98.5	98.5	98.3	98.5	98.4	98.1		
HR	88	69	62	63	59	65	70		
RR	15	16	16	14	14	13	14		
SAO2	99%	99%	99%	98%	99%	99%	100%		

1330 First unit complete. — [redacted] 9/6/06

1345 Pre-transfusion vitals taken + blood verified. Starting Second unit. — [redacted] 9/6/06

b(6)-2

Time	1345	1355	1400	1405	1420	1435	1450	1520
BP	121/53	103/53		95/56	102/55	110/51	100/61	108/65
Temp	98.5	97.8	97.9	98.0	98.1	97.9	97.6	97.8
HR	88	69		62	60	70	77	75
RR	14	15	16	16	18	16	16	14
SAO2	100%	100%	100%	99%	98%	95%	99%	99%

1530 Second unit complete, VSS, Ø Reaction Ntd. Will Continue to monitor. — [redacted] 9/6/06

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO | WARD NO

[redacted] b(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 505
Prescribed by GSA/ICMR FPMR 41 CFR 101-11.4

b(6)-2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 July 03 0707	Pt. resting in bed c̄ eyes closed. Easily aroused. Ø distress noted. Will continue to monitor. Sgt [redacted]
0817	To OR. [redacted]
0957	Return from OR. BP 117/71 Resp 6 SpO2 100% on RA O2 HR 80. Pt. received general anesthesia. Will continue to monitor pt. [redacted]
1026	Pt. resting in bed c̄ eyes closed. Easily aroused. Ø complications/distress noted @ present time. Will continue to monitor pt [redacted]
1054	Pt. resting in bed c̄ complaints @ present time ~~[illegible]~~ ~~[illegible]~~ Carrying on conversation c̄ PFC [redacted]. Ø distress noted SpO2 100% on RA. Will monitor. [redacted]
1100	Received orders to transfer to FCW 2-EPW. Word. [redacted]
1118	C/o stump pain 4mg MSO4 IV given for complaint. Will continue to monitor. [redacted]
1124	VS; HR 104 SpO2 100 RR 8 BP 123/80 Temp 98.8. Condition remain stable. [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(6)-2 KH

15 Jul 03 1630 Pt sitting up in bed interacting c̄ staff & appears to be in a cheery mood. VSS, H&H ↑ Following transfusion, see lab sheet for results. Will continue care. [redacted] 91WM6

1700 Received report from day shift. [redacted] 91WM6

2200 Pt appears to be resting comfortably [redacted] VSS, will continue to monitor. [redacted]

0200 Pt resting comfortably in bed. Will continue to monitor. [redacted] SPC, 91WM6

0430 Drew am labs. [redacted] SPC, 91WM6

0500 Gave report to day shift. [redacted]

0517 Told to not place Foley by Maj [redacted] Reported to day shift (SGT [redacted] SPC, 91WM6

0550 Received report from SPC [redacted] 91C held off via shift charge nurse (Major [redacted] night shift) & distress noted this am. ∅ complaints voiced @ present time. Pt. resting in bed c̄ eyes closed. Will continue to monitor for any S&S of distress. [redacted]

16 July 03 0013 C/O stump pain. 2mg MSO4 IV given for complaint. Will continue to monitor. [redacted]

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

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

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b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (Rev
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0 JUL 03	Surgery op note
	Preop Dx: Non-healing GSW to RLE w/
	substantial bone loss & infection
	Proc: Right BKA
	Surg: [redacted] / [redacted]
	EBL: 150cc
	Fluids: 1L LR
	UO: 250cc
	Complications: Ø
	Comment: wound looking healthy approximated
	Drains: Penrose
	Stable to ICU - will return in 48 hours
	[redacted] b(6)-2
18 Aug 03	Brief note
	Pt Dx: Infected BKA Rt Dx Sm
	Pt. Sh. Verbal delusions
	Sign [redacted] b(6)-2 Ans [redacted] b(6)-2
	Pt. Delusional denial mental
	problem compounded. Must be
	TD Psychiatry [redacted] b(6)-2

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

SPONSOR'S NAME [redacted] | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or w[redacted]le; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

EPW # [redacted]
b(6)-4

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

#3

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 JUL 03	SURGERY OP NOTES
	PREOP DX: OPEN BKA
	PROC: REVISE + CLOSE STUMP + WASHOUT
	SURG: [redacted] b(6)-2
	EBL: 150 cc
	FLUIDS 1300 cc LR
	UO: 350 cc UO
	COMPLICATIONS: Ø
	JP 10 mm IN STUMP
	STABLE TO RECOVERY / ICU [redacted] b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

CAL RECORD

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PROGRESS NOTES

NOTES

7-16-03 1238 Pt. tx to ICW #2 from ICU#3 via litter. Pt. crying out in pain. 2mg MSO4 given IVP. PICC line to (L)AC CDI, flushes well, positional. CRI @ 100cc/hr. HL to (R) wrist intact. HR Reg. Scattered insp wheezes. ABR soft ± BS (+) x4. (R) stump dsng CDI, ↑ on pillow. Will cont. to monitor. [redacted]

7160 3 1308 - Received PT in bed c/o pain to (R) stump. PT VSS. Lung sounds are clear Bilateral. Skin is warm + Dry. Good PMS on upper extremities + (L) leg. BSX4 (R) stump Dressing is dry + intact. PT was given TI Percocet TAB @ 1300 Per pain. CR @ 100cc/hr to (L) wrist running well ∅ no S/S infection. Heplock (R) arm CDI. HR Reg. Abd soft soft ∅ BSX4. Will continue to monitor for pain. [redacted]

16 July - PT will be NPO after midnight. [redacted] b(6)-2

16 July 1955 - PICC line was D/C ∅ tip intact. [redacted]

17 July 03 0050 Pt. awake & alert in bed. Pt ∅ continues c/o pain for the past 3 hours despite medication administration, now comfortable ∅ complaints. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. (R) BKA dressing slowly becoming saturated ∅ bld, reinforced DSG ∅ additional ace wrap. HL to (R) wrist flushed well ∅ 3cc NS ∅ S/S of infection.

SHIP TO SPONSOR

SPONSOR'S NAME

LAST | FIRST | MI | SPONSOR'S ID (SSN or Other)

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IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; (2) No or SSN, Sex, Date of Birth, Rank/Grade)

REGISTER NO | WARD NO ICW2

EPW# [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

TE	NOTES
17July03 0050	Ⓡ LE ↑ @ 30° c̄ rolled blanket underneath. All other assessment findings WNL. Will continue to monitor drainage from Ⓡ LE. Pt NPO for I&D this AM. [redacted] T. AN
0610	Pt. care assumed @ 2100. VSS. Pt. c/o pain Ⓡ UE. 4mg MSO4 given IVP. Ⓡ wrist HL intact, flushed. Ø S/S infection. HR Reg, lungs CTA, BS@XY. Ⓡ stump↑, dsg Dry & intact. Will cont. to monitor. Pt NPO for surgery — [redacted] UTAN.
17JUL03	0930 c/o pain in Ⓡ leg. Pt medicated as ordered c̄ 4mg MSO4. IV. S.L. flushed easily, site c̄ redness or edema. Resting quietly @ present. — [redacted]
17July03	Brief Rel Surg Dx - Infected Ⓡ BKA Proc - Washout Ⓡ BKA Surgeon [redacted] Anes [redacted] Fluids Normal Saline Specimen on chemo Closed wound / Seen by Surgeon on Ward Pre OR Atrm [redacted] b(6)-2 AN

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MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
17Jul03 1800	assumed care @ 1300 - pt. returned from surgery @ 1600 - VSS - S/P BKA (R) washout - (R) FA IV SL'd ⊽ pt. tol. regular diet for dinner - lungs CTA (B) - (+) BS - no u.o. since surgery, DTV by 2300 - pt. NPO ⊽ MN for washout in AM - labs ordered in AM - pt. c/o small amount of pain in (R) LE, will continue to monitor - dsg on (R) BKA CDT and stump elevated on pillow - [redacted] RAN
18July03 0000	Pt. asleep in bed ⊽ complaints @ this time. (R) BKA ↑ @ 30° on folded blanket. DSG to (R) BKA CDI. HR Regular, Lungs sounds clear bilat, bowel sounds (+) x 4 quads. HL in (R) FA ⊽ s/s of infection. Pt. to be NPO since MN for washout this AM. VSS. All other assessment findings WNL. Will continue to monitor. [redacted] RAN
0700	Pt. care assumed @ 0500. VSS. HR Reg, LS CTA bilat. BS (+) X4. HL to (R) FA flushed ⊽ diff, ⊽ s/s infection. DT NPO for surgery. ∅ pain @ this time. (R) BKA ↑ ⊽ dsg CDI. Will cont. to monitor. [redacted] RAN

b(6)-2

b(6)-2

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

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REGISTER NO.

WARD NO.

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
Prescribed by GSA/OCMB FPMR (41CFR) 101-1

FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE | NOTES

18 Jul 03 Brief of Pt
Prep OR - Initial (R) BKA
Prep OR - Wound Cont final
Prep - (R) BKA washed
and dry
Surgery [redacted]
Complete @

[redacted]

1100 Pt. back from PR via litter. VSS, @ pain. LR @ 125 cc/hr to (R) wrist HL. HK Reg, lungs CTA, BS (+) x4, ABD flat, firm. (R) stump dsng CDI, ↑ on blankets. JP draining bright red bloody drainage. Pt. resting quietly. Will cont. to monitor. [redacted]

1900 Assumed care of Pt @ 1300. VSS. A+O x3. Pain controlled with PO Percocet - Amb. s assistance on crutches. (R) BKA Dry ACE. JP drain 30cc bloody drainage. HL PIV (R) FA 1 U NBX. O/W Assess. WNL. Will Monitor [redacted]

19 Jul 03 Rec'd c/o pt @ 21:00. Asleep in bed. Awakened easily. VS WNL per flow sheet. Restraints x2 (R) wrist (L) ankle. LCA (B). BS (+) hypoactive x4. (+) PPP (B) x [redacted] (R) BKA stump ACE wrap DSG C/D/I. @ c/o pain @ this time will cont. to mon [redacted]

b(4)-2 A1

b(6)-2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7-19-03	0705: Pt. care assumed @ 0500. VSS. Pt. given 2 Percocet for pain @ 0600. Pt. assisted to BR on crutches for BM. HR Reg, lungs CTA, BS (+) x4. (R) K E stump ↑. Dsng CDI. HL to (R) AC intact s/s infection. [redacted]
1900	Assumed Care of Pt @ 1300. VSS. A+O x3. Pain controlled c̄ percocet. (R) BKA Dsg/ace CDI c̄ JP Drain c̄ sml amount bloody drainage. (R) PA SCT IV ABX. O/w Assessment WNL. will monitor [redacted]
2100	Pt returning from BR on crutches had syncopal episode. Staff caught Pt. Placed in Bed. VSS O_2SAT 98% pulse 140's. Rested for 3 min. VSS. BP: 104/70 P: 110 R: 26 O_2SAT: 98% Pt A+O x3. Rest [redacted] Rel will monitor [redacted]
2401	Duoderm applied to 2° Skin Ulcer Lower Back [redacted]
19 July 03	2210 Assume pt care @ 2100. pt Asleep easy to awake. Alert. Skin pale warm and dry to touch. VSS. HL to (R) AC no s/s redness/infiltration c̄ flush. HR reg lungs CTA. Abd soft flat BS x4. (R) BKA Dsg CD+I JP drain draining sm amt bloody drainage. Duoderm to lower back CD+I. Will continue to monitor [redacted] Slumb
20 July 03	0820- Pt alert lying in bed. VSS, lungs CTA, HR reg, BS(+). Pulses (=) + strong x 3. Ace wrap to (R) BKA, CDI. HL to (R) AC. Voiding c̄ catheter. Will cont. to monitor. JP draining small amount of red fluid [redacted] 2 bone

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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 JUL 03 1330	Assumed care of Pt @ 1300. VSS. A+O x3. ⊖ c/o pain. (B) LS CTA (+) BS x4 HR; (R) BKA drsg CDI. JP draining serous fluid. (R) AC HLT IV ASV patent. O/W assessment WNL. NPO for OR. Will monitor — [redacted]
1332	Duoderm to sacral skin ulcer CDI — [redacted]
1500	Ortho Op Note Dx s/p (R) BKA b(w)-2 Ant Rx Dsg Δ Surgeon [redacted] Anes MAC Findings wound dry, healing [redacted] well MAJ [redacted]
1630	Pt returned from OR. VSS. A+O x3. (B) LS CTA (+) BS x4. Stump drsg CDI. Will monitor — [redacted]
1915	D/C IV (R) AC infiltrated, ~~extravated~~. New 18G PIV started (L) FA. patent — [redacted]
21 JUL 03 0050	Rec'd pt care @ 21:00. VS WNL. per flowsheet. Awake and alert in bed. LCA (B). BS (+) x4. (+) PPP (-) ROM stump. (+) skin w/D. c/o pain x2 ii Percocet given will cont to monitor [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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b(w)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
	# 376		

DATE	NOTES
7-21-03 0642	Pt. care assumed @ 0500. VSS. Pt. c/o pain (R) BKA. ¡ Percocet given. HL to (L) FA flushes ¯ diff. HR Reg, lungs CTA Bilat, ABD soft BS (+) x4. (R) BKA ↑, dsng CDI. Will cont. to monitor. b(6)-2 [redacted]
1900	Assumed care of Pt @ 1900. VSS. A+O x3. Pain controlled ¯ percocet. (R) BKA dsng/ace wrap CDI. (L) FA PIV patent ¯ IV ABX. O/W assessment w/c. Will monitor b(6)-2 [redacted]
22 July 03 0145	Pt. asleep in bed. Pt. ¯ c/o pain @ 0030, medicated ¯ II percocet. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. (R) BKA ↑ on folded blanket. HL in (L) FA flushed well ¯ 3cc NS ¯ s/s of infection. DSG to (R) BKA CDI. Pt ¯ complaints @ this time. Will continue to monitor [redacted]
22 July 0615	Assume pt care @ 0500. pt Awake b(6)-2 and Alert. VSS. no c/o pain or discomfort @ this time. HR reg Lungs CTA. Abd soft BS x4. (R) BKA DSG CD+I. HL to (L) FA no s/s redness/infiltration ¯ flush. Will continue to monitor b(6)-2 [redacted] Plump.
22 Jul 03 1700	assumed care @ 1300 - VSS - SL [redacted] patent - dsg intact on (R) BKA - medicated for pain ¯ II percocet PO ¯ good results - pt. able to ambulate ¯ crutches ¯ difficulty - MD to [redacted] dsg today [redacted] CR, AN

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b(6)-2

[redacted]

b(6)-1

MEDICAL RECORD	PROGRESS NOTES — AUTHORIZED FOR LOCAL REPRODUCTION
DATE	NOTES b(6)-2

22Jul03 2045 ~~assumed care @ 1300 - VSS - medication~~ ~~tr Percocet PO @ 1615 - good results -~~ dressing remains in place on decubitus on bottom [redacted]

22Jul03 2245 Rec'd c/o pt @ ~~22~~ 21:00. VS WNL per flowsheet. Restraint x1 (R) wrist. Pt awake and alert. Skin color WNL. PERRLA (+) WNL. LCA (B). HR WNL/Reg. BS (+) x4. (R) ↓ BKA ACE wrap intact. Denies pain @ this time will cont. to mon [redacted] /RN

23 Jul Assumed care of pt @ 0000. Pt asleep. VSS. Lungs CTA. Bowel sounds x 4 quads. Pt woke up constipated. Pt was given warm milk to drink. Pt was able to use BR. 2 hours later. Pt is now asleep again. Pt does not c/o pain/discomfort @ this time. Will continue to monitor. [redacted] /PN, SGT

23July03 1405 assumed pt care @ 1300. pt lying in bed refused lunch tray. VSS. lungs CTA, abd soft BS (+) x4 quads (R) BKA dressing CDI. (L) leg c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulses. HL (R) BKA ⊖S/Sx of infection noted. ⊖% pain/discomfort. Will cont to monitor [redacted] 9 WMC

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)

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[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

23JUL03

NOTES

23:42 Rec'd c/o pt @ 21:00. Restraints x1 (R) wrist. VS WNL per flowsheet. Pt sleeping in bed easily awakened. Skin W/D. PERRLA (+) WNL LNB. BS (+) x4. HL patent (R) F/A. (R) PPP (+). (R) BKA ACE wrap dsg C/D/I. c/o's. Will cont. to mon [redacted] 23 AW

24July03 0535 Assume pt care @ 0500. pt Awake and Alert. VSS. HR reg Lungs CTA. Abd soft no c/o tenderness on palpation BS x 4. (R) BKA ace wrap intact pt NPO for OR today. No c/o pain. HL to (R) FA no s/s redness/infiltration ~ flush. Will continue to Monitor [redacted] b(6)-2 [redacted] 24 MMP

24JUL03 0500 assumed care @ 1300 - VSS - pt. c/o to OR, NPO since midnight, LR @ 100cc/hr started due to >12° NPO - pt. has no c/o pain @ this time [redacted] b(6)-2 [redacted] CR AW

7/24/03 [illegible] OR [illegible]
Pre Op (R) BKA today Dx - [illegible]
[illegible] Pre Op [illegible] b(6)-2 [illegible]
Sig [redacted] [illegible]
[illegible]
Pre [illegible] good [illegible] / [illegible]
No [illegible]

SPONSOR'S NAME FIRST MI | SPONSOR'S SSN NUMBER SSN of Other

HOSPITAL OR MEDICAL FACILITY [redacted] MAINTAINED AT b(6)-2

[illegible] a written letter, give: Name - last, first, middle; SSN or VSE No.; Date of Birth; Rank/Grade

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EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE

NOTES b (6)-2 A 11

sutures & exudate noted @ this time c/o pain. ↑ Percocet given. AL (R) FA & patent. New IV placed. Will cont. to mon. [redacted] SGT/AN

26 July 03 0515 Assume pt care @ 0500. Pt awake and alert. No c/o pain or discomfort @ this time. VSS. HR reg Lungs CTA. Abd soft BS×4 (R) BKA Cast CD+I (R) Knee stitches intact. Area around stitches red and tender. No IV site @ this time. Will cont. to monitor. [redacted] Shuma

26 JUL 03 2000 assumed care @ 1800 - VSS - sutures intact, area remains discolored, tender to touch - medicated for pain c ↑ Percocet PO - dsg CDI on (R) BKA - [redacted]

26 JUL 03 2151 Rec'd c/o pt @ 21:00. Restraints x1 (L) wrist. VS WNL per flow sheet. Pt awake and alert in bed. Perrla (+) WNL. LOA (B) BS (+) x4. (+) PP (B). (R) BKA DSG C/D/I Sutures to patella, CTA C (+) S x5 infection (+) redness (+) edema & pitting around sutures & c/o pain @ this time. will cont. to mon. [redacted] SGT/AN

27 July 03 0630 Pt. awake & alert sitting up in bed eating breakfast. HR Reg, lung sounds clear bilat, bowel sounds (+) x4 quads. Pt. c/o pain, ↑ Percocet given @ 0735. (R) BKA DSG CDI. Sutures to (R) knee intact, skin surrounding

SHIP TO SPONSOR

SPONSOR'S NAME

LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

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b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R

DATE	NOTES
24Jul03 2000	assumed care when pt. returned from surgery - dsg intact, sutures open to air, intact, no drainage noted. IV S/L'd @ pt. tol. regular diet - pt. given scheduled Plavix and ii percocet PO for pain - drowsy but arousable. Sacral decubitus ulcer - [redacted] CNA
24Jul03 23:01	Rec'd c/o pt. @ 21:00. Restraints x 2 x 1 (R) wrist. VS WNL per flowsheet. Skin W/D. LCA (R). PIV HL to (R) FA patent/intact. (R) BKA C dsc C/D/I. sutures to patella C/D/I. Sxs infection (+) redness (+) swelling. c/o pain @ this time. will cont. to mon. [redacted] RT/AN
25Jul03	0713 - Pt alert cite 75% of breakfast. VSS, lungs CTA, HR reg, BS (+). (R) BKA c dsg C/D/I. Sutures to patella intact. HL to (R) forearm → patent. Voicing Ø complaints at this time. Will cont. to monitor — [redacted] 24 AN
25Jul03 1400	assumed care @ 1330 - VSS - SL patent - dsg C/D/I on (R) BKA, sutures intact, area around sutures appears ecymotic, purple in color - no c/o pain @ this time — [redacted] CRA
25Jul03 1830	pt. had 2 loose BM this shift - medicated x 1 for pain in (R) knee (R) — [redacted] CNA
25Jul03 21:51	Rec'd c/o pt. @ 21:00. Restraints x 1 (R) wrist. VS WNL per flowsheet. Pt. awake and alert in bed. PERRLA (+). Skin W/D. LCA (R). BS (+) x 4. (+) APP (R). (R) BKA dsg C/D/I. sutures to patella intact C (+) sxs infection (+) redness around

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27July03 0630 Sutures c̄ erythema noted, skin warm to the touch. Pt. c̄ IV access. All other assessment findings WNL. Pt c̄ other complaints @ this time. Will continue to monitor. [redacted] JAN

27Jul03 1415 assumed care @ 1300 - VSS - no c/o pain @ this time - dsg CDI on (R) BKA, sutures intact, area c̄ reddish erythema noted, tender and warm to touch - [redacted] CRJAN

27Jul03 0024 Rec'd c/o pt @ 21:20. Restraints x2 (R) wrist. VS WNL per flow sheet. Pt sleeping in bed easily awakened. Skin W/D. LCA (B). BS (+) x4 (+) PP (B). Sutures to (R) knee C/D/I. area around sutures (+) S/S infection (+) redness. DSG to (R) leg C/D/I. c/o pain @ this time will cont. to mon [redacted] JAN

28July03 0900 Pt. awake & alert in bed. c̄ complaints. VSS. Pt. c̄ IV access. HR Reg, lung sounds clear bilat, bowel sounds (+) x4 quads. DSG to (R) BKA CDI, sutures to knee intact: erythema noted on surrounding skin & warm to touch. Pt. c/o pain @ 0730, ī Percocet given. All other assessment findings WNL. Will continue to monitor. [redacted] JAN

28Jul03 1900 assumed care @ 1300 - VSS - medicated for (R) Knee pain c̄ ī Percocet PO @ 1855 - dsg CDI on (R) leg, sutures intact, redness diminishing @ suture site - encouraged pt. to do PROM on (R) Knee

SPONSOR'S NAME

LAST	FIRST	MI	SPONSOR'S ID NUMBER SSN or Other

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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STANDARD FORM 509

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MEDICAL RECORD — ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28Jul03	pt. demonstrated understanding of PROM
cont.	ambulated to BR c crutches, had BM — [redacted]
2330	Pt care assumed @ 2100. VSS, alert and awake, ↑ pain b(6)-2
28July03	given for pain @ 2300. Lungs CTA, BS⊕ x4. Sutures CTA on
	ⓡ BKA intact. Slight erythema noted on knee. Pt ambulated,
	stopped due to dizziness, and to be carried back to bed.
	Performed ROM x30 minutes and massaged muscles, understands
	need for ROM. Continue to monitor. [redacted] b(6)-2
29July03	0550 Assume pt care @ 0500. pt awake and
	alert. VSS. HR reg. Lungs CTA. Abd soft BS x4. ⓡ BKA
	stitches intact OTA, redness noted. Skin breakdown
	to lower back, OTA pt encouraged to lay on side.
	No c/o pain or discomfort @ this time, will
	encourage ROM and amb. c crutches. — [redacted]
	1400 Pt stable at this time. AAOx3. PERRLA
	Lungs CTA bilat, ∅ resp distress. NSR. Abd
	soft, non-tender, bowel sounds active
	x4 quads. Strong pulse, brisk cap refill
	and good strength to bilat upper extremity
	and ⓛ leg. Sutures to ⓡ knee CDI, site
	reddened. Sutures to stump CDI. Pt expressing
	ⓡ knee. ∅ complaints — [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MANAGEMENT
			b(6)-2
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. ICW2

EPW# [redacted]

b(6)-4

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

b(6)-2 A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1630 29 July 03	Every other suture removed from suture line on stump. Site CDI, wound healing well, good approximation of wound edges. Granuloma above suture line on stump draining serosanguinous fld. ∅ complaints. [redacted]
29 JUL 03 01:48	Rec'd c/o pt @ 21:00. Restraints x1 ® wrist. Pt VSWNL per flow sheet. Awake and alert in bed. Doing ROM exercises to ® leg/stump. Perrla ⊕ WNL. LCA ⊕ BSx4 ⊕ PP ⊕. HR Reg. ® stump @ patella sutures intact C/D. ⊕ sxs infection ⊕ redness ⊕ tenderness ⊕ ↑ warmth noted around sutures. Sutures @ stump C/D/I. DSD c̄ scant amt yellow drainage noted. ∞ dos @ this time will cont to mon [redacted]
30 July 03 0030	Pt. asleep in bed easily aroused by verbal stimuli. HR Reg, lung sands clear bilat, bowel sands ⊕ x 4 qdrants. Sutures intact on ® knee & amputation site, erythema surrounding sutures on ® knee c̄ ↑ temp. Pt. VSS. Pt. s̄ IV access. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted]
30 Jul 03 1930	Assumed care @ 1300 - VSS - medicated for pain c̄ ↑ Percocet @ 1400 c̄ good results, no c/o pain @ this time - Sutures to be removed 31 Jul and if wound stays closed pt. will go to EPW camp - pt. wrapped stump c̄ kerlix to prevent sutures from rubbing on sheet - wound covered c̄ 2x2, small amt. serosanguinous drainage noted - [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD PROGRESS NOTE ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Jul 03 2307	Rec'd c/o pt @ 21:00. Restraints x 1 (R) wrist. VS WNL per flowsheet. Awake and alert in bed. Skin WNL WD PERRLA (+) WNL. LCA (B). HR Reg. S1S2 WNL. BS (+) x 4. (+) APB c/o pain x 1 ~~i~~ Percocet given. Sutures to stump OTA. Will cont. to mon [redacted] OTA/AD b(6)-2
310550 July 03	Nursing Assessment: Assumed pt. care. Airway intact, breath, even and unlabored, LS clear to all fields (B). Abd soft, nontender, ~~i~~ distended. Voids spontaneously. Skin [redacted] and neurovascularly intact. Stump to (R) LE, dsg CDI. (R) IV access. [redacted]
311000 July 03	Nursing: Sutures removed from stump and knee per orders of physician. Upon removal of sutures from knee, pt bent knee and wound reopened. Conferred ~~i~~ Dr. [redacted] 2 Dr. [redacted] not available. Steristrips ~~i~~ benzoine applied per Dr. [redacted] suggestion [redacted]
31 July 03 1305	- Assumed pt care. Breath and Ae clear B/lateral. VSS. BS x 4. Abdomen soft. PT has (+) ROM to upper extremity + (-) Cg. PT has (-) c/o pain currently. Stump to (R) LE is Dry + intact ~~i~~ steri strip to the knee. PT exhibits no discomfort from stump and is resting in bed. Will cont to monitor [redacted]
31 Jul 03 23:15	Rec'd c/o pt @ 21:00. Restraints x 1 (R) wrist. Awake and alert in bed. Skin W/D. PERRLA (+) WNL. LCA (B). BS (+) x 4. (+) APB (B) (B) BKA steristrips intact. c/o pain @ this time. Will cont. to mon. [redacted] OTA/AD

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. ICW2

EPW # [redacted]

b(6)-4

PROGRESS NOTE ~~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	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1 Aug 03	0650: Assumed pt. care @ 0500. Pt. awake A+O x3. lungs CTA. +Pulses. ⊕BS x4. sterile strips on ⓡ knee. Denies any complaint of discomfort. [redacted]
1400	Pt stable at this time AAOx3 PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Brisk cap refill and strong pulses to bilat UE and ⓛ leg. ⓡ stump c̄ steri strips open to air. Suture line CDI. Pt exercising ⓡ knee. ∅ complaints — [redacted]
01 Aug 03 21:31	Rec'd c/o pt @ 21:00. Restraints x1 ⓡ wrist. VS WNL per flow sheet. Sleeping in bed easily awakened. Skin WNL W/D. PERRLA ⊕ WNL. LCAB HRRS, S2WNL. BS⊕x4, ⊕PP⊕. ⓡ BKA c̄ kerlix dsg C/D/I. Stump soft and warm to touch. ∅ apparent S/S infection. c/o pain x1 ÷ Percocet given. Will cont to mon. [redacted]
2 August 03 0915	[redacted]. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 qu. Pt. ∅ IV access. Am care completed. Pt. removed sterile strips on his ⓡ knee, wound is open c̄ patellar tendon visible. Skin around wound is red c̄ ↑ temp. MD notified. Sterile strips reapplied & 4x4 applied. Pt. c̄ limited ROM of knee. All other assessment findings WNL. Pt ∅ complaints @ this time. Will continue to monitor. [redacted]
2 Aug 03 1900	Assumed care @ 1300 - VSS - medicated for c/o pain c̄ (Percocet) PO @ 1430 c̄ good results - (R) Knee dsg Δ'd, 2x2 w/ ABD dsg done, skin open, patellar tendon visible, area around wound remains red, small skin tear above & below wound — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 12723

b(u)-2 A11

b(6)-2 A71

NSN 7540-00-634-4176 600-108

HEALTH RECORD PROGRESS NOTES ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4Aug03 1900	assumed care @1300 - VSS - medicated for pain @1500 c̄ 650mg tylenol PO c̄ good results - dsg Δ'd - (R) Knee, wound edges red, ~2x2in opening c̄ patellar tendon visible, w/ ⊃ dsg applied, Keeli placed - pt ambulated to BR c̄ crutches, had BM - [redacted]
4Aug03 23:48	Rec'd pt @21:00. Restraints x2 (R) wrist (L) ankle. VS WNL per flow sheet. Pt. awake and alert requesting pain med. ii Tylenol given. Pt refused tylenol. Brr la (L) wrist. Skin w/D: LCA (B). HRRSS. BS x4. (+) PP (B). @2354 pt. decided to take ii Tylenol (R) stump keeli dsg C/D/I. No further complaints with mon. [redacted] /AN
5Aug03	0535 Assume pt care @ 0500. Asleep easy to arise. No c/o pain or discomfort @ this time. VSS. HR reg Lungs CTA Abd Soft BS x4. (R) BKA dsg CD+I. Will continue to monitor — [redacted] /WMG
5Aug03 2030	assumed care @1300 - VSS - dsg Δ'd twice this shift - O/C to OR in AM, NPO p MN for surgery 6Aug03, pt aware of plan - medicated c̄ tylenol ii PO @1400 c̄ good results — [redacted] b/c

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

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

1CW2

EPW

#[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Aug 03 21:45	Rec'd c/o pt. @ 21:00. Restraints x2 (R) wrist (R) ankle. VS WNL per flow sheet. Pt. awake and alert in bed. Voicing concerns to interpreter that he wants to "receive care in an Iraqi Hospital because the doctor scared him when stated he was to have an AKA". Dr. [redacted] aware of pt's feelings. PERRLA (+) WNL. LOA (B). HRR S1S2. BS (+) x4. (R) stump wrapped c̄ Kerlix dsg CDI. (+) PP (B). c/o pain x1 iī Tylenol given. Will cont to mon [redacted] /AN
030510 Aug 03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields. Abd soft, nontender, ↓ distention. BS (+) x4. Urinates spontaneously. Flow and sensation intact to all extremities. (R) LE stump, suture line intact c̄ staples to all suture sites. Kerlix gauze to (R) knee, CDI. ø IV access. — [redacted]
2 AUG 03 1300	- PT is resting in bed c̄ (-) c/o pain or discomfort. VSS. Heart: Rhythm and bilateral. BS x 4. (R) stumped wrapped + ↓ CDI. Skin ↓ warm + Dry c̄ (-) s/s of infection. Will cont to monitor PT. [redacted]
2130	Pt. care assumed @ 2100. VSS. Pt. c/o pain (R) LE @ stump. iī Percocet given. HR Reg, lungs CTA, BS (+) x4. Dsg to (R) stump CDI. Will cont. to monitor. — [redacted]
4 Aug 03 0600	Pt. VSS. No IV access. HR Regular, lungsounds clear bilat, bowel sounds (+) x 4 quads. DSG to (R) BKA CDI, limited ROM. Pt. ↓ complaints @ this time. All other assessment findings WNL. Will continue to monitor — [redacted] /LTAN
0830	W→D DSG Δd to (R) knee. Patellar tendon clearly visible through half dollar size wound. Edges of wound are red & temp is ↑. No drainage noted. — [redacted]

b(6)-2 All

NSN 7540-00-634-4178 600-108

HEALTH RECORD — ~~CHRONOLOGICAL RECORD OF MEDICAL~~ CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Aug 03 2240	Pt care assumed @ 2100. VSS, alert and awake 3 c/o pain after 650 mg tylenol @ 2000. Lung sounds CTA, pulses (+) x4, DS (+) x4. Ext fix on (R) LE. CDI, pt c̄ (+) BOM, sensation in rle. Pt to have ex fix dc/d tomorrow, expected to return to EPW camp on 7 Aug 03. Will continue to monitor. [redacted] 9 Aug 03
6 August 03 0600	Pt awake & alert in bed. New IV placed in (L) FA for surgery this AM. Pt. is been NPO since MN. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. DSG to (R) BKA CDI, limited ROM to (R) knee. Pt. 5 complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 6/AM
6 Aug 03	Brief or not Surg Dx - Open [illegible] wd Pre op Dx - [illegible] Procedure - Advancement-flap closure of [illegible] wound plus [illegible] of [illegible] with [illegible] Surg [redacted] Assist Capt Clevenger Anes GET [redacted] Findings - Debrided wound and advanced V flap with good full thickness closure of [illegible]

b(6)-2 A1

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

EPW

[redacted]

b(6)-4

RECORDS MAINTAINED AT: [redacted]		
PATIENT'S NAME		SEX
RELATIONSHIP TO SPONSOR		RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06 Aug 03 1130	Pt. back from OR. Vitals stable [redacted] Pt. c̄ cast to (R) leg s̄ complaints @ this time. [redacted]
06Aug03 1400	Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft non-tender, bowel sounds active x 4 quads. Strong pulses and brisk cap refill x 3 extremities. Cast to (R) BKA CDI. [redacted] 1CT/AN
2130	A care assumed @ 2100. Temp @ 100.6, pulse @ 122, 650 mg tylenol given. A alert and awake, no c/o pain at this time. Lung sounds CTA, BS x4. Osg on (R) BKA CDI. A c̄ discharge summary and orders on 7Aug, will continue to monitor. [redacted] 9Lunco
7Aug03	0530 Assume pt care @ 0500. Awake and Alert c/o pain to (R) BKA. percocet given. Cast to (R) BKA intact VSS x̄ temp 99.4 HR reg Lungs CTA Abd soft BS x4. plan for Discharge today. HL to (L) FA ⊕ flush s̄ s/s redness/infiltration. will continue to monitor [redacted] 3Lunco
7Aug03 1350	assumed care @ 1300 – VSS – medicated c̄ ii Tylenol PO for c/o pain [redacted] ~ 1330, pt. Sleeping @ present – cast intact on (R) BKA – pt. awaiting transport to EPW camp [redacted]
	b(6)-2 A11

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER:

ARRIVAL DATE DAY	MONTH	YR.	TIME
1	JUL	03	2255

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [ ] AMBULANCE [X] OTHER (Specify) Medevac

CURRENT MEDS. (tetanus immunization and other data): None

HISTORY OBTAINED FROM: [ ] PATIENT [ ] OTHER (Specify)

ALLERGIES: NKDA

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

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

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

SEX: ♂ AGE: 24

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

VITAL SIGNS			
TIME	2255		
BP	103/61		
PULSE	79		
RESP.	18		
TEMP.	98.2		
WT. (Child)	150		

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:

(R) T.b X-Fix & (L) hypothenar tendon repair ≈ 20-25 days ago in Iraqi hosp. presents for follow-up care. PMHx

(S) X Fx (R) t.b open wound.
(L) hypothenar F/q.ed i sutures.

CATEGORY (See reverse)

X	EMERGENT
	URGENT
	NON-URGENT

ORDERS	INITS.	TIME
~~[illegible]~~ XR7		
CBC Metpan [redacted]		2300
	662	

ASSESSMENT/DIAGNOSIS: (R) X-Fix / (L) hypothenar sutures

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: ORTHO.

CONDITION UPON RELEASE

	IMPROVED		UNCHANGED
	DETERIORATED		

TIME OF RELEASE:

b(6)-2

(CONTINUE ON SF 507, IF NEEDED) [redacted]

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).

[redacted] b(6)-4

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] / MD

INSTRUCTIONS TO PATIENT (Include medications [redacted] any limitations and follow-up plans)

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 27

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
[X] NKDA [ ] PCN [ ] LATEX [ ] IODINE [ ] TAPE [ ] FOOD
REACTION:

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

4. PROPOSED SURGICAL PROCEDURE: s/p GSW (L) hand & (R) tibia

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition intact w/ wound sutures
Tobacco ___ ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM ↓ ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ancef, morphine

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g.. warm blanket. touch). Explain all nursing procedures before they are done. Remain with pt. whenever possible. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Pt. will be able to breathe without difficulty during immediate intraoperative phase .	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

[redacted] b(6)-4

[redacted] b(6)-2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since MN ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards ✓ 3) Prosthesis 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ~~✓ 3) Arthritis~~ KN	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from either side. ø Validate pt.'s understanding of verbal communication. ø Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] b(u)-2 CPT/AN 3 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☒ Moves Upper Extremities

☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(u)-2

DATE: 2 Jul 03 TIME: 1000

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

DATE: 3 July 03 TIME: 1500 b(u)-2

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 27

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
[X] NKDA [ ] PCN [ ] LATEX [ ] IODINE [ ] TAPE [ ] FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex Fix (R) Tibia, I+D (R) Tibia

4. PROPOSED SURGICAL PROCEDURE:
(R) Tibia I+D -vs- BKA

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition (R) L + foot necrotic
see HP
Tobacco ___ ppd X ___ yrs. Body Piercing ø Diabetes (Y) (N) ROM ___ ASA/Motrin w/72 hrs (Y) (N)
ETOH ø Implants ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	ø Pt. verbalizes any specific anxiety. ø Pt. Exhibits relaxed body posture.	ø Allow pt. to verbalize freely. ø Explain OR environment and answer questions regarding surgery. ø Offer comfort measures. (e.g.. warm blanket. touch). ø Explain all nursing procedures before they are done. ø Remain with pt. whenever possible. ø Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	ø Pt. will be able to breathe without difficulty during immediate intraoperative phase .	ø Offer to elevate head of litter or offer pillow. ø Observe pt. while awaiting surgery for signs of distress. ø Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	ø Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	ø Utilize pressure preventing devices on OR table and accessories. ø Check for proper positioning and support to maintain good body alignment. ø Pad pressure points. ø Place ESU ground pad on non compromised skin surface area. ø Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
[redacted] b(u)-2
ICU-3

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since noon ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to: ___ 1) Intraoperative Mobility ___ 2) Positioning ___ 3) Existing Disease ___ 4) Safety Devices ___ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to: ___ 1) Pain ___ 2) Intraoperative Hazards ___ 3) Prosthesis ___ 4) Positioning ___ 5) Transfer pt. to/from OR table E.2. ___ Potential discomfort due to: ___ 1) Length of Surgery ___ 2) Positioning ___ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ___ Diminished visual perception due to being: ___ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ___ Potential for decreased communication due to: ___ 1) Diminished Hearing ___ 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period. Imaginational	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] b(6)-2 6 July 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N) b(6)-2

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☒ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 6 July 03 TIME: 1530 b(6)-2

13. POSTOPERATIVE EVALUATIO[redacted] BY (Signature and Title) [redacted] CPT/AN

DATE: 6 July 03 TIME: 1940

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 25

HEIGHT: /

WEIGHT: 65 lbs

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
[X] NKDA [ ] PCN [ ] LATEX [ ] IODINE [ ] TAPE [ ] FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
GSW (R) Tibia & (R) Leg s/p [illegible]

4. PROPOSED SURGICAL PROCEDURE:
I&D amputated (R) leg

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ~~ASA/Motrin w/72 hrs (Y) (N)~~
ETOH_____ Implants_____ ~~Respiratory Disease (Asthma/COPD) (Y) (N)~~ Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment X 2) Separation Anxiety (Child) X 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids X 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

[redacted]

blue-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOME	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning X 3) Existing Disease X 4) Safety Devices X 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: X 1) Pain X 2) Intraoperative Hazards X 3) Prosthesis X 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery X 2) Positioning X 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ____ Diminished visual perception due to being: ____ 1) Pre-Medicated ____ 2) W/O Glasses F.2. X Potential for decreased communication due to: ____ 1) Diminished Hearing X 2) Language Barrier F.3. ____ Potential injury due to dentures: ____ 1) Upper ____ 4) Caps ____ 2) Lower ____ 5) Crowns ____ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] b(6)-2 12 July 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to liter with roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y)(N)
BREATHING EASY: (Y)(N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2
DATE: 12 July 03 TIME: 0650

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b(6)-2
DATE: 0656 TIME: 12 July 03

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Gurney BY Anesthesia

2. PATIENT IDENTIFIED VERIFIED BY CPT [redacted] PROCEDURE b(4)-2

3. DATE 3 July 03 TIME PATIENT ARRIVED IN SUITE 1855

4. PATIENT IN ROOM TIME 1855 NUMBER 1-1 18

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: proper body alignment maintained, 2 armboards used for positioning of left arm, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

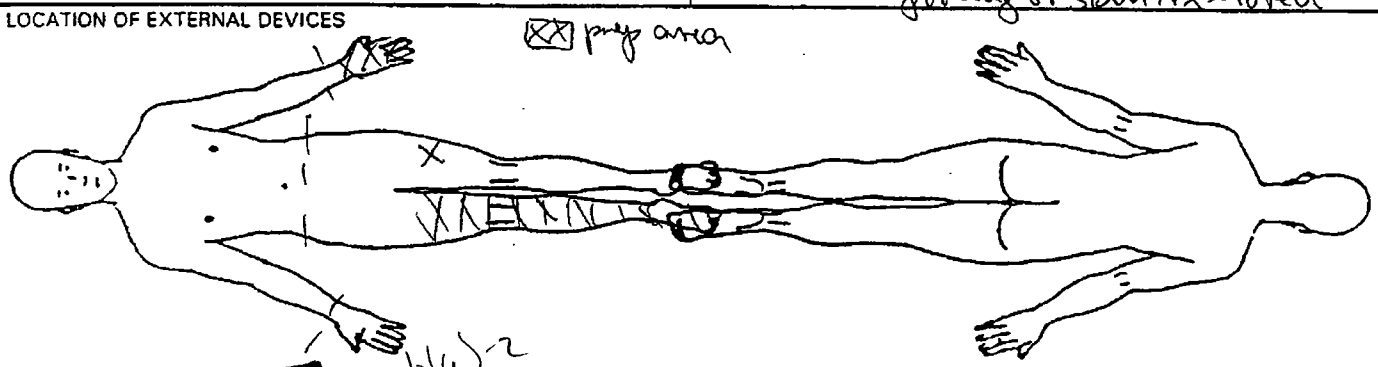
PREP SOLUTION (Specify) Betal Betal

SITE: (R) Leg to 3 in above knee BY WHOM [redacted]

SITE: (L) hand BY WHOM: [redacted]

COMMENTS: no pooling or skin rx noted b(4)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					
Needle Sharp	☐ Yes ☒ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

[redacted] b(4)-4

ICU #3

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

☐ ESU NO: Valleylab Force 2 ~~#24~~ Dwarden #4

GROUND PAD: BRAND Valleylab Rem Polyhesive II

LOT NO: 69652 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS. SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16 F FIC		
SITE	Bladder		

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

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b(6)-2

- FIC in place upon arrival to OR

20. OPERATION(S) PERFORMED
I+D (R) tibia fx + I+D (L) hand

21. PATIENT TRANSFERRED TO ICU- b(6)-2 TIME See DA7389 METHOD Liner & Safety [redacted]

[redacted] NURSE SIGNATURE
[redacted]

REVERSE OF DA FORM 5179-4, OCT 87 USAPA V1.01

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSFERRED TO OPERATING ROOM VIA: Litter BY Anesthesia

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

3. DATE 6 July 08 TIME PATIENT ARRIVED IN SUITE 1735

4. PATIENT IN ROOM TIME 1735 NUMBER 1-1 | 6

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
	PFC [redacted] (out @ 1835)		
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1910-EOC)
	Maj [redacted] (out @ 1845)		

7. POSITION AND POSITIONAL AIDS (Specify)

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

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

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

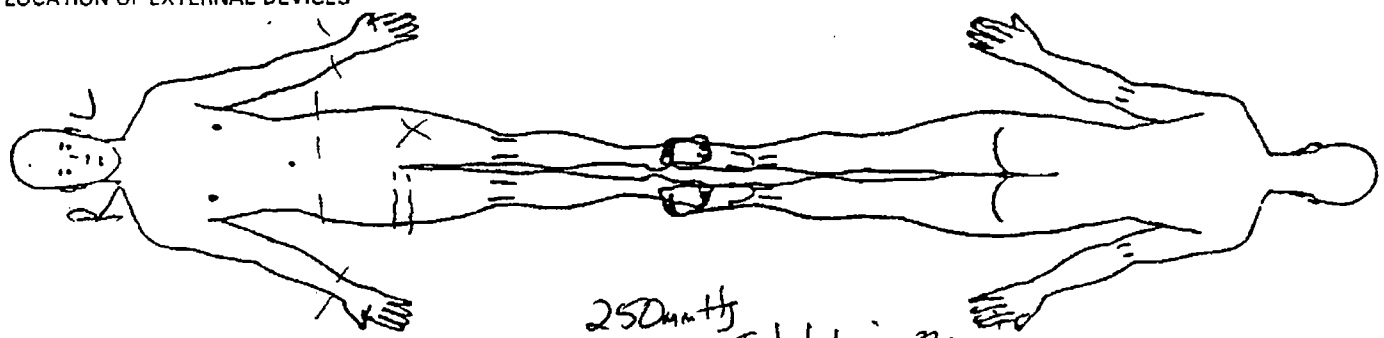
PREP SOLUTION (Specify) Betal Beta b(6)-2

SITE: (R) Leg BY WHOM [redacted]

SITE: BY WHOM:

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



250 mm Hg Total time 33 min 15

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

10. COUNTS

C = Correct I = Incorrect b(6)-2

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

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

[redacted] ICU-3

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: Valleylab Force #2 # 4

GROUND PAD: BRAND Valleylab Rem Polyhesive II

LOT NO: 69652 2005-04

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		
[redacted]		

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16F F/C	3/8 in Penrose	
SITE	Bladder	(R) leg	

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Ace wrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b(6)-2
- F/C in place prior to arrival to OR

20. OPERATION(S) PERFORMED
(R) BKA, Dressing Δ (L) hand

21. PATIENT TRANSFERRED TO ICU 3 b(6)-2 | TIME 1940 See DA7389 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT AN [redacted]

REVERSE OF DA FORM 5179-7, [redacted] b(6)-2 USAPA V1.01

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

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

3. DATE 8 Jul 03 TIME PATIENT ARRIVED IN SUITE 0815

4. PATIENT IN ROOM TIME 0815 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: NPO p MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Supine on padded OR table. BUE on padded armboards <90°.

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

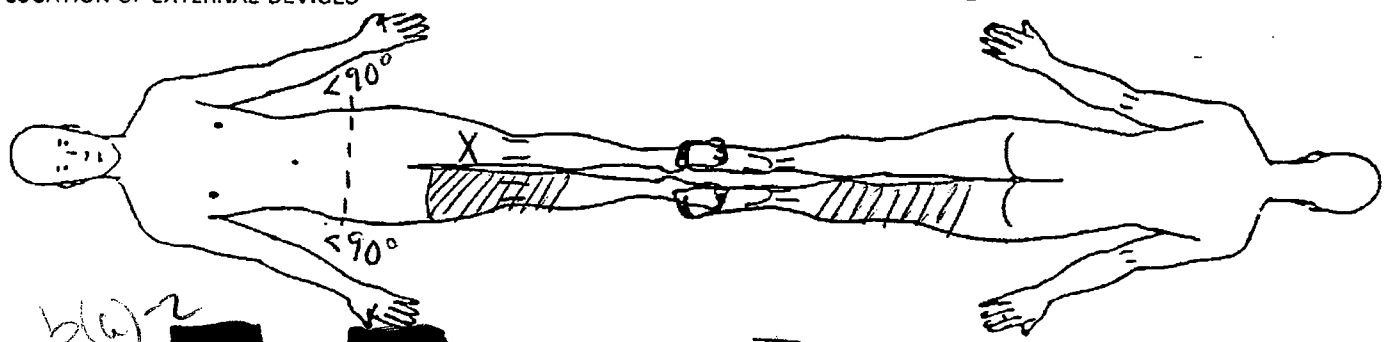
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [X] YES [ ] NO Dr. Nessen
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR
[ ] CLIP (R) BKA stump
COMMENTS: No nicks or cuts

PREP SOLUTION (Specify) Betadine/Betadine
SITE: Right leg BY WHOM:
SITE: BY WHOM: ILT [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted]

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

Initial: PFC [redacted] ILT

C = Correct I = Incorrect

10. COUNTS

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No	/			PFC [redacted]	ILT [redacted]
Needle Sharp	[X] Yes [ ] No	/	C	C		
Instrument	[ ] Yes [X] No	/	/	/		
Other	[ ] Yes [X] No	/	/	/		

b(6)-2

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

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: # 000450 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive #
LOT NO: 657016 Exp 2004-11

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

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. #10 J-P drain	2.	3.
SITE	1. Right BKA Stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted] Dr. [redacted]
Anesthesia: MAJ [redacted] b(6)-2

GETA

Pt. arrived in OR c̄ patent Foley cath.

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Revision & wash-out RBKA

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	1004	LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] 7N

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: Litter BY OR Staff

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

3. DATE 11 Jul 03 TIME PATIENT ARRIVED IN SUITE 1310

4. PATIENT IN [redacted] TIME 1310 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: arms extended on armboards ∠90° bilaterally

8. SKIN PREPARATION

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

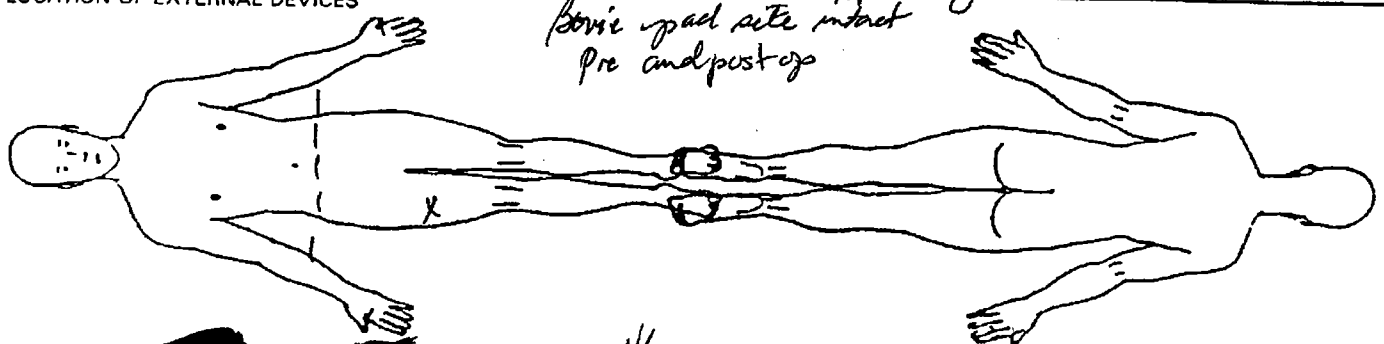
COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Rt leg BY WHOM: Maj [redacted]
SITE: BY WHOM: b(6)-2

COMMENTS: ⊕ pooling

9. LOCATION OF EXTERNAL DEVICES

Bovie pad site intact pre and post op



LEGEND X Gr[illegible]d -- S[illegible] Strap = = = Tourniquet N/A

b(6)-2

C = Correct I = Incorrect Initial: [redacted]

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

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

[redacted]

b(6)-4

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

☐ ESU NO: cut 30 coag 30 Valleylab
GROUND PAD: BRAND Valleylab
LOT NO: 65706

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NS

OTHER ORDERS	TIME	CARRIED OUT BY
None [redacted]		

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

15. X-RAY IN OPERATING [redacted] IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

fluffs
Kerlix

19. ADDITIONAL INFORMATION

WC II

Surgeon: [redacted] b(4)-2

Anesthesia: [redacted]

20. OPERATION(S) PERFORMED

I&D Rt stump

21. PATIENT TRANSFERRED TO PACU b(4)-2 TIME 1414 METHOD Litter

22. R[redacted] SIGNATURE MAJ An

REVERS[redacted]A FORM 5179-1, OCT 87 USAPA V1.01

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Gurney BY OR personnel

2. PATIENT IDENTIFIED, REC[illegible]D AND PROCEDURE VERIFIED BY Cpt [redacted] b(6)-2

3. DATE 12 Apr. 03 TIME PATIENT ARRIVED IN SUITE 0555

4. PATIENT IN ROOM TIME 0600 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

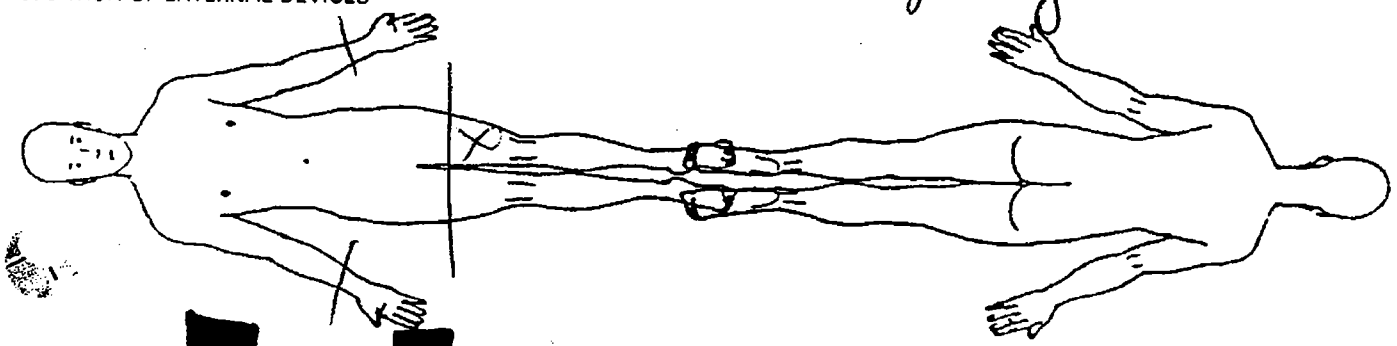
PREP SOLUTION *(Specify)* Betadine Soap/scrub

SITE: (R) stump + thigh BY WHOM:

SITE: BY WHOM: LTC [redacted]

COMMENTS: No pooling b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

b(6)-2

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

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

[redacted]

b(6)-4

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

☒ ESU NO: 1

GROUND PAD: BRAND Valleylab

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

cut: 30 coag: 30

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

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

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

kerlix, fluff, 4x8, DG

19. ADDITIONAL INFORMATION

Anesthesia - CRT Watson, CRNA

Surgeon - Dr [redacted] b(6)-2

20. OPERATION(S) PERFORMED

I&D Lt. amputation stump/ leg

21. PATIENT TRANSFERRED TO ICU #3 b(6)-2 TIME 0614 METHOD via litter

[redacted] ITC, AN [redacted]

[redacted] OF DA FORM 5179-1, OC [redacted] b(6)-2

USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

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

3. DATE 13 July 03 TIME PATIENT ARRIVED IN SUITE 0755

4. PATIENT IN ROOM TIME 0755 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: NPO p MN. NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL [redacted] - supine on padded OR table BUE on padded armboards <90° Safety strap across mid-abdomen.

[ ] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

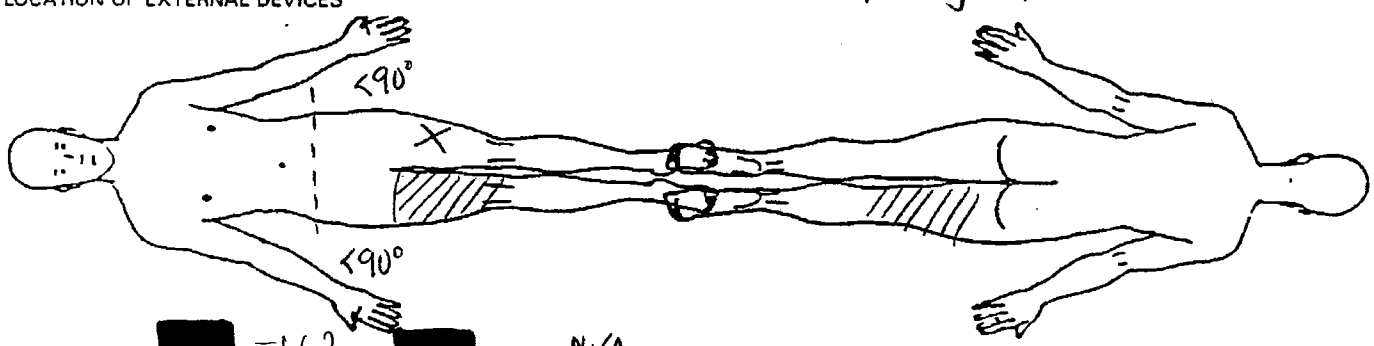
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

PREP SOLUTION (Specify) Betadine/Betadine
SITE: Right Leg BY WHOM: CPT [redacted]
SITE: BY WHOM:

COMMENTS: No pooling or adverse reaction b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] b6-2 -- Safety Strap N/A = = = Tourniquet

Initial: PFC [redacted] ILT [redacted]

C = Correct I = Incorrect

b(6)-2

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

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

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: # 4 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68936 Exp 2005-03

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA [illegible] IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Hibiclens Lot 3721H Exp 05/04	Q.S.	intra-op	local application	mfr: Regent Med	Dr [redacted]
					b(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
N		
A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Fluff packing ⊂ Betadine / NaCl soln.	2.	3.
SITE	1. Right BKA Stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted]
Anesthesia: MAJ [redacted] & MAJ [redacted]
b(6)-2

DA 5179 InChart

20. OPERATION(S) PERFORMED
Wash-out Right BKA stump

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU		LITTER ⊂ O2

22. REGISTERED NURSE SIGNATURE [redacted] b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.0

MEDICAL RECORD

INTRAOPERAT[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY anesthesia

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

3. DATE 14 JUL 03 TIME PATIENT ARRIVED IN SUITE 1835

4. PATIENT IN ROOM [redacted] TIME 1835 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: in proper body alignment

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

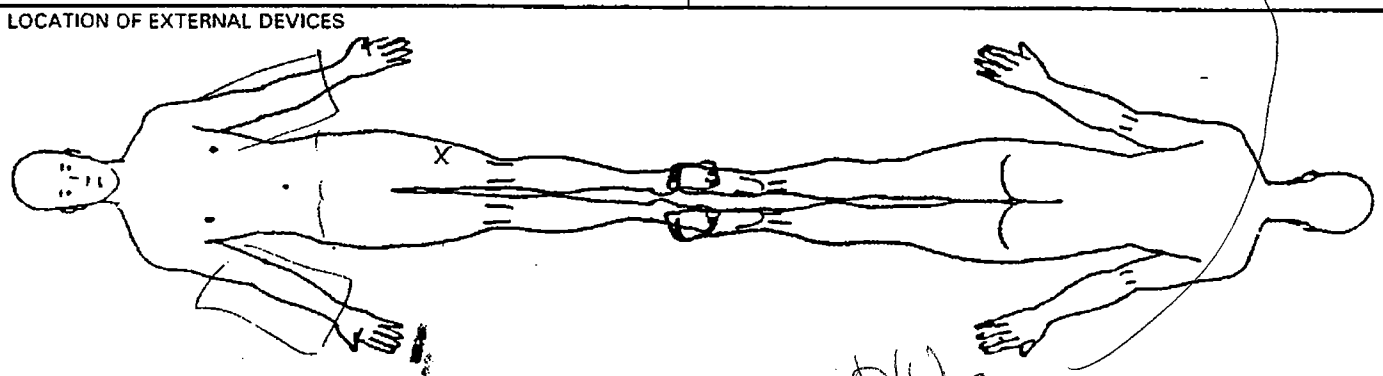
PREP SOLUTION *(Specify)* Betadine scrub/sol'n

SITE: (R) BKA stump BY WHOM: [redacted]

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial [redacted] b(6)-2

10. COUNTS

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

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

[redacted]

b(6)-4

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

☒ ESU NO: 4

GROUND PAD: BRAND Valleylab

LOT NO: #68936

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
ABD
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surgeon: [redacted]

Anesthesia: [redacted]

20. OPERATION(S) PERFORMED

I & D (R) BKA stump

21. PATIENT TRANSFERRED TO: ICW 3 TIME: 1925 METHOD: Litter w/anesthesia

22. REGIS[redacted] SIGNATURE [redacted] CPT ION

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Gurney BY OR/Anesth.

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

3. DATE 15 Jul 03 TIME PATIENT ARRIVED IN SUITE 0659

4. PATIENT IN ROOM TIME 0700 NUMBER 1-1 | 4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc. [redacted] b(6)-2	RELIEF SCRUB	PFC [redacted] b(6)-2
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	CPT [redacted] 0715-EOC

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

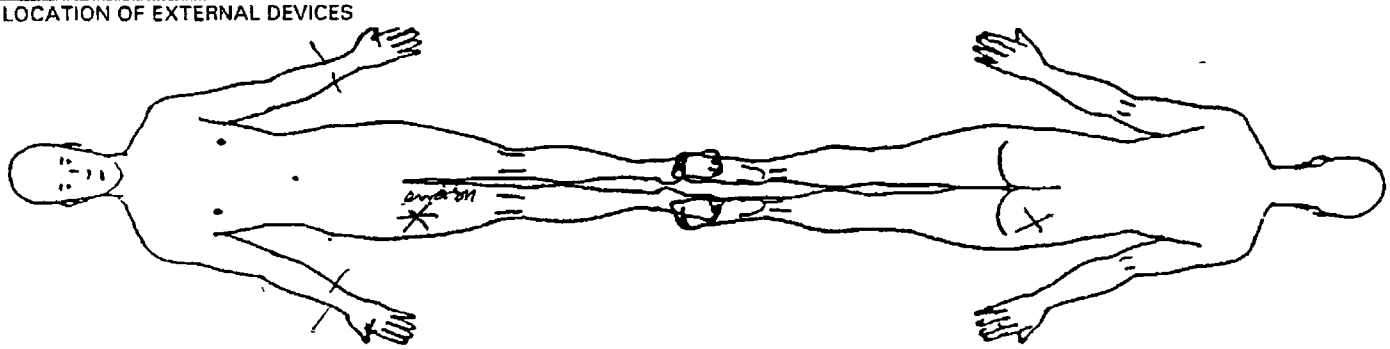
PREP SOLUTION *(Specify)* Betadine Scrub/Sol BY WHOM [redacted]

SITE (R) Leg (BKA) BY WHOM: b(6)-2

SITE:

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

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

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

#[redacted]

b(6)-4

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

☒ ESU NO: Valleylab Force 2 #4

GROUND PAD: BRAND VL Rem Polyhesive II

LOT NO: 68936 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none [redacted]		
[redacted]		
[redacted]		
[redacted]		

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Flaps ABD
Kerlix
Aceways

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b6-2
- see previous DA 5179 for pre-op assessment and Nursg Dx -> no A's

20. OPERATION(S) PERFORMED
I+D Right BKA
Close Knee wound (R)

21. PATIENT TRANSFERRED TO ICU-3 | TIME see DA 5179 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

b(6)-2

MEDICAL RECORD — **INTRAOPERA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY O-R Staff

2. PATIENT IDENTIFIED, RECORD REVIE[redacted] PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 17 Jul 03 TIME PATIENT ARRIVED IN SUITE 1 Cu³ → OR

4. PATIENT IN ROOM TIME 0820 NUMBER 2-1/1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPO p MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT. [redacted] (1st FST) b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: (B) arm to padded arm board <90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

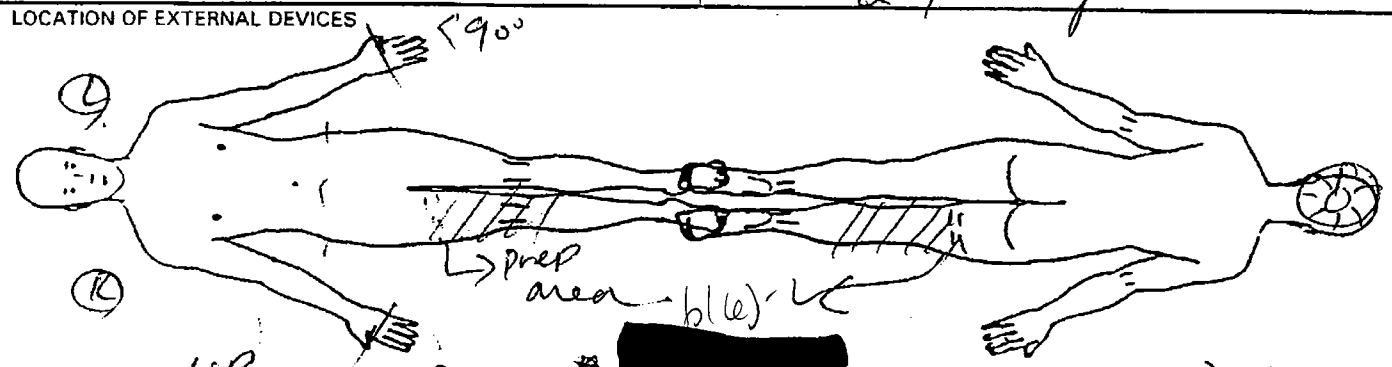
PREP SOLUTION *(Specify)* Betadine S/Sol

SITE: Rt BKA to thigh BY WHOM:

SITE: BY WHOM:

COMMENTS: ⊗ poolings

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad UP -- Safety Strap UP = = = Tourniquet [redacted] 275 mmHg 25 minutes b(6)-2

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	SGT [redacted]	CPT. [redacted]
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;)*

EPW # [redacted]

b(6)-4

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

☑ ESU NO: Valley Lab

GROUND PAD: BRAND polyhesive II

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO: [redacted] b(6)-2 Cut-30

DA FORM 5179-1, OCT 87 REPLACES D[illegible] CH IS OBSOLETE. USAPA V1.01

MEDCOM - 12751

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Normal

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. Kerlex fluff		3.
SITE	1. (Rt) Knee	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)

fluffs ABD's
Kerlix
Ace

19. ADDITIONAL INFORMATION

Dr. [redacted] / Dr. [redacted]
RPT. [redacted] (CRNA) b(6)-2

20. OPERATION(S) PERFORMED

(Rt). BKA Revision, washout & debridement

21. PATIENT TRANSFERRED TO	TIME	METHOD
b(6)-2 ICU	See Anes. Record	Litter

22. [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDICAL RECORD — **INTRAOPERATI[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

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

3. DATE 17 JUL 03 TIME PATIENT ARRIVED IN SUITE 1134

4. PATIENT IN ROOM TIME 1134 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER *(Specify)*

COMMENTS: NPOP MN, NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. supine on padded OR table. BUE on padded arm boards <90°

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

PREP SOLUTION *(Specify)* Betadine / Betadine

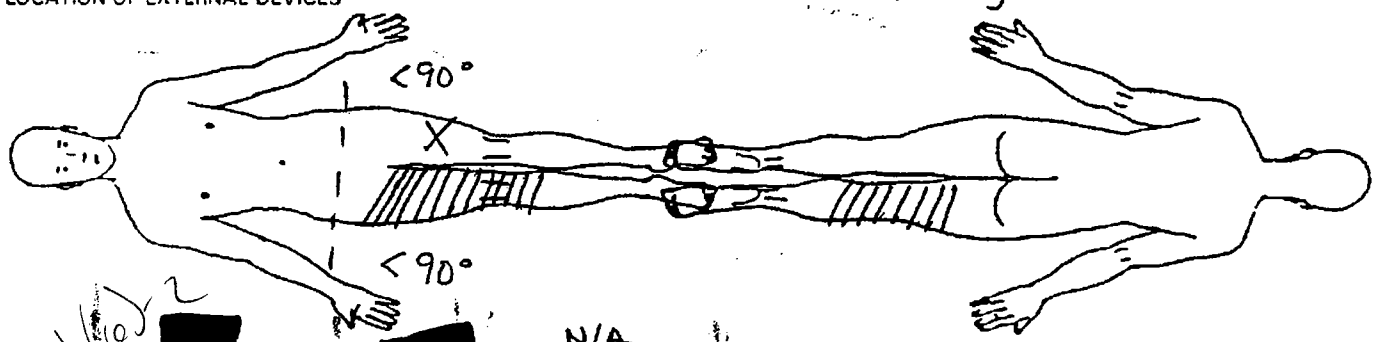
SITE: Right leg BY WHOM: ILT [redacted]

SITE: BY WHOM:

Hibiclens scrub intra-op by Dr. [redacted]

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted] N/A

LEGEND X Ground Pad -- Safe[redacted]trap = = = Tourniquet ▨ - prep

Initial: SGT [redacted] ILT

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB b(6)-2	CIRCULATOR
Sponge	[X] Yes	[ ] No					
Needle Sharp	[X] Yes	[ ] No		C	C	SGT [redacted]	ILT [redacted]
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

EP W # [redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: #4 CUT 30 COAG 30

GROUND PAD: BRAND VL REM Polyhesive II

LOT NO:

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlix fluffs & Betine Soln.	2.	3.
SITE	1. Right BKA stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION
SURGEON : Dr. [redacted]
ANESTHESIA : MAJ [redacted] b(6)-2

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Wash-out BKA Stump

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1438	LITTER & O2

22. REGISTERED NURSE SIGNAT[redacted]T/AN
b(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

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

3. DATE 18 July 03 TIME PATIENT ARRIVED IN SUITE 0730

4. PATIENT IN ROOM TIME 0730 NUMBER 1-1 1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: See previous DA 5179 for pre-op assessment + Nsg. dx → no Δ's

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
	SSG [redacted] b(6)-2		
ASSIGNED CIRCULATOR	ILT [redacted]	RELIEF CIRCULATOR	
	CPT [redacted]		

7. POSITION AND POSITIONAL [redacted]

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS: correct body alignment maintained, arms on padded arm boards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

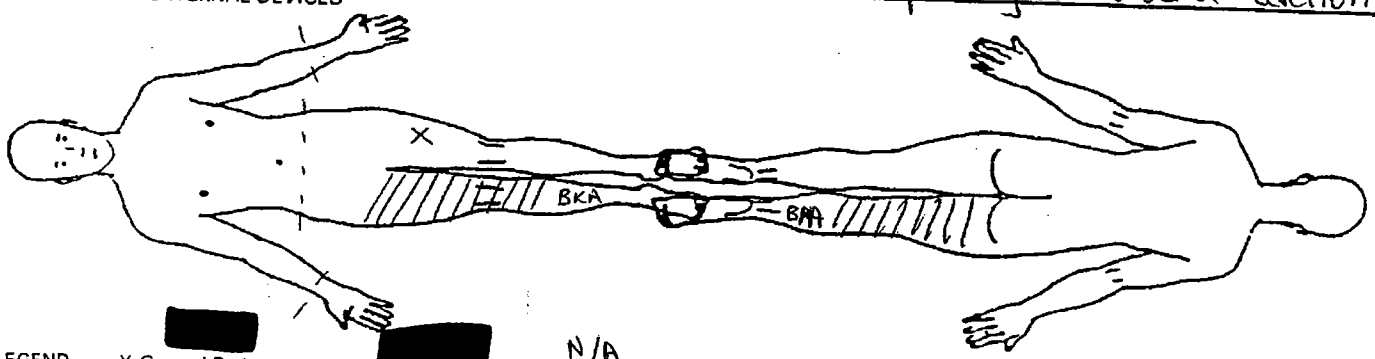
PREP SOLUTION (Specify) Betadine/Betadine

SITE: Right leg BY WHOM: CPT [redacted]

SITE: Right leg Hibiclens Scrub in drags BY WHOM: Dr. [redacted] b(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap N/A = = = Tourniquet

Initial: PFC Nedd ILT Malachi

C = Correct I = Incorrect

10. COUNTS

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

b(6)-2

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

1 [redacted]

ICW-2 b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: #4 CUT 30 COAG 30

GROUND PAD: BRAND VL REM PONTHESIVE II

LOT NO: 68936 EXP 2005-11

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10 mm TP	2.	3.
SITE	1. (R) BKA Stump	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Xeroform
Kerlix
Acuwrap

19. ADDITIONAL INFORMATION

Surgeon [redacted]
Anesthesia; [redacted] b(6)-2

DA 5179 in Chart

20. OPERATION(S) PERFORMED
I+D (R) BKA + closure of wound

21. PATIENT TRANSFERRED TO ICU-2 b(6)-2 | TIME See DA7389 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/A [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia

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

3. DATE 20 July 03 TIME PATIENT ARRIVED IN SUITE 1445

4. PATIENT IN ROOM TIME 1445 NUMBER 1-

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

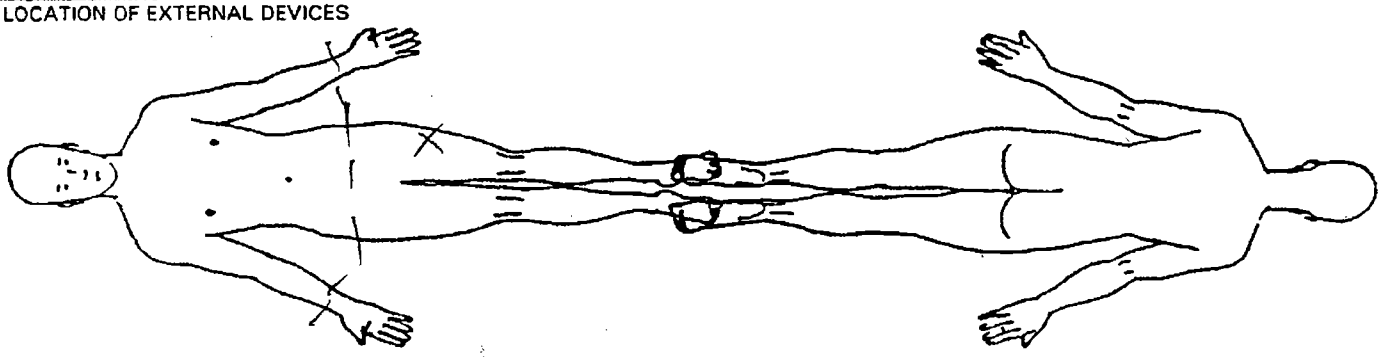
PREP SOLUTION *(Specify)* N/A

SITE: BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted] b(6)-4

ICW-2

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

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

MEDCOM - 12757

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Xeroform
Kerlix
Acuwrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted] - DA 5179 on chart
Anesthesia: [redacted] b(6)-2 All

20. OPERATION(S) PERFORMED
~~I+I~~ error [redacted] Drsg Δ. (R) BKA

21. PATIENT TRANSFERRED TO ICU 2 | TIME See DA7389 | METHOD Litter

[redacted] REGISTERED NURSE SIGNATURE [redacted] CPT IAN

REVE[redacted]T 87 [redacted] USAPA V1.01

MEDICAL RECORD — **INTRAOPERA[illegible]OCUMENT**

For use of this form, see AR 40-66, the propone[illegible]ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Gurney BY Anesth.

2. PATIENT IDENTIFIED, RE[redacted] AND PROCEDURE
VERIFIED BY LTC [redacted] b(6)-2

3. DATE 24 Jul. 03 TIME PATIENT ARRIVED IN SUITE 1515

4. PATIENT IN ROOM
TIME 1515 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt [redacted] LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL [redacted]

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

COMMENTS:

8. SKIN PREPARATION

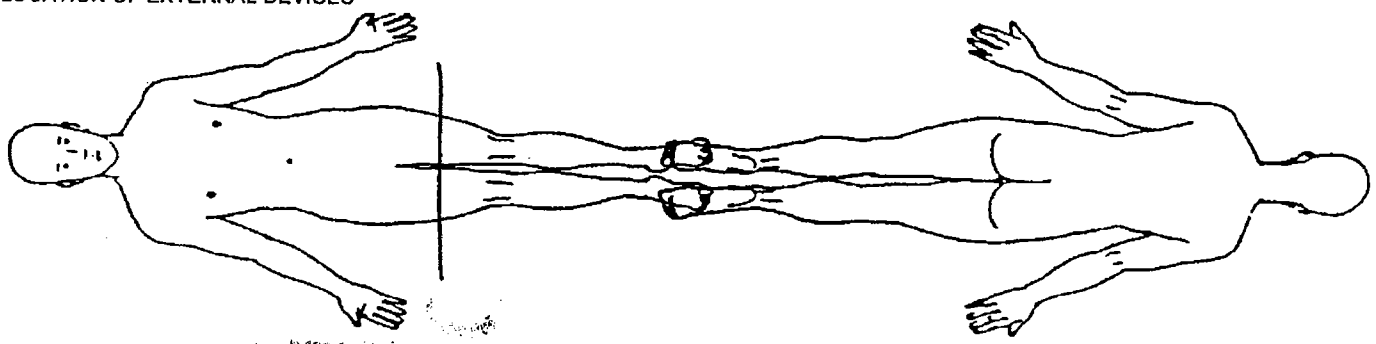
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* N/A
SITE: BY WHOM:
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes ☒ No					
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;)*

[redacted]
b(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: Cpt [redacted] CRNA Anesthesia Type:
b(4)-2 Cpt [redacted]

- DA 5179 on chart, Ø Δ's

Bovie Pad site intact pre-op NA ; post-op NA Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op NA ; post-op NA
Tourniquet Time: Up NA Down NA

20. OPERATION(S) PERFORMED
(R) BKA Dressing Change under anesthesia

21. PATIENT TRANSFERRED TO ICU2 TIME See DA7389 METHOD via Gurney

22. [redacted] TC, AN [redacted] CPT/AN
b(4)-2 b(4)-2

REVERSE OF DA FORM 5179-1, OCT [redacted]

MEDCOM - 12760

USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Cart BY Anesthesia

2. PATIENT IDENTIFIED, [redacted] AND PROCEDURE VERIFIED BY ILT [redacted]

3. DATE 6 Aug 03 TIME PATIENT ARRIVED IN SUITE 0800

4. PATIENT IN ROOM TIME 0800 NUMBER b(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO PMN, NKDA

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt. supine on padded OR table, BUE on padded armboards < 90°

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

COMMENTS: Normal anatomic body alignment maintained b(6)-2

8. SKIN PREPARATION

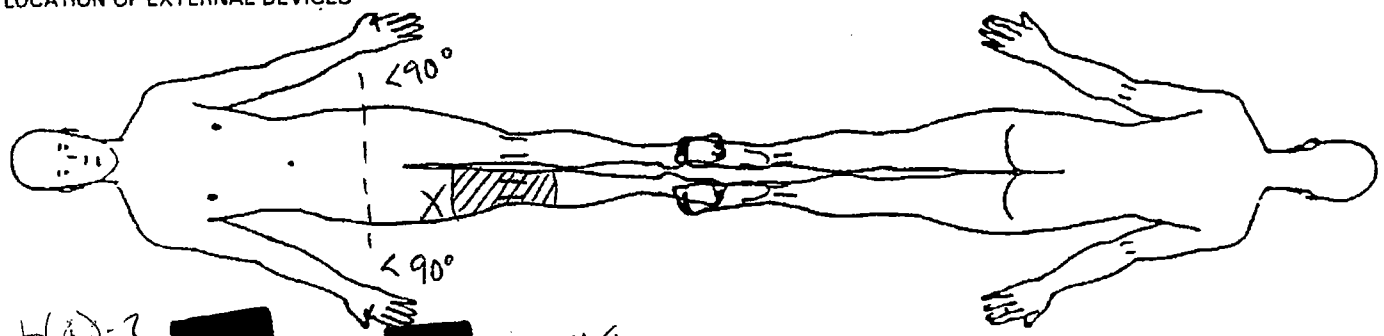
HAIR REMOVAL ☒ YES ☐ NO ILT [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT b(6)-2
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP Right leg

COMMENTS: No nicks or cuts noted

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Right leg BY WHOM: ILT [redacted]
SITE: BY WHOM:

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



b(6)-2 [redacted]

LEGEND X Ground Pad -- Safety Strap = = = Tourniquet N/A - PTCP

Initial: SGT [redacted] ILT

C = Correct I = Incorrect

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

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

[redacted]

b(6)-2

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

☒ ESU NO: 4 cut 30 coag 30
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlix, fluff, kerlix webril, cast

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted] b(6)-2

DA 5179 in chart

20. OPERATION(S) PERFORMED
Closure (R) knee wound

21. PATIENT TRANSFERRED TO ICU3 b(6)-2 | TIME See DA7389 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] RN [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PT'S NAME:

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP				111/66									110/68				115/70				111/67			
TEMP				96.3									98.5				98.2				98.4			
HR				77									69				72				70			
RR				12									18				22				18			
SA02				100%									100%				98%				98%			
method				NRB																				
INPUT	~~125~~			~~125~~																				
PO	NPO	NPO	NPO	~~NPO~~ NC																				
IV	125	125	400	125																				
NGT																								
FeNt	50			~~250~~																				
TOTAL																								
OUTPUT																								
URINE		450													1000					950				
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 12764

PATIENT ASS[illegible]NT

ME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature Warm

: Pale / Cyanotic / Jaundiced Normal for Race

ous Membranes: Moist / Dry / Cracked

Breakdown: None Location: Size:

NEUROLOGICAL

Alert / Lethargic / Unresponsive GCS:

nated / Disoriented Pupils: 3mm

emity Movement: Full / Limited / None

CARDIOVASCULAR

e (0 - 4): Radials +2 Pedals L +2 R +1

illary Refill: Seconds >3 Homan's Sign

lar Venous Distension Ø Edema

t Sounds S1 S2

hm RRR PRI: QRS:

ular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
eforms				
tion				

st Pain

RESPIRATORY

st Expansion / Symmetrical / Asymmetrical

piration / No Distress / SOB / Labored / Use of Access Muscles

thing Patterns: Reg Rate Rythm

gh: Productive / Nonproductive / None

um: Color / Amount / Consistency / Odor NONE

st Drainage System Gravity: N/A Suction cm:

Leak No Yes N/A Crepitus

racter of Drainage:

hea / Midline / Deviated (R) / Deviated (L)

icial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
ckles	CTA	Bilat
ezes		
nished		
ent		

GASTROINTESTINAL

omen Soft / Firm / Hard / Distended / Distention cm Girth

el Sounds: Normal / Hyperactive / Hypoactive / Absent

ssings: R Lower Extremity, L Hand

Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

Drainage: Color Character

e Feeding: Day No: N/A Strength: Rate: Aspirate:

ol: Character

ns

GENITOURINARY

e Color: yellow Character: Clear

ding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Pt resting in bed Ø S/S of pain or discomfort

HER

ENT ASSESSMENT b(6)-2

TIME: 2000 SIGNATUR[redacted]

SKIN AND MUCOU[redacted]MBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal to race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils: 3mm

Extremity Movement: Full / Limited / None X RLE

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals R +2 L +1

Capillary Refill: Seconds < 3 Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2 Ø ectopy

Rhythm RRR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Pe
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Mu

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/
Crackles	CTA	
Wheezes	Bilat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girt

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: RLE & L hand

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: As

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP		111/57										109/58				110/56				111/51				
Temp		98.1										97.9				98.1				98.1				
HR		83										76				82				83				
RR		21										18				17				18				
SAO2		96										96				95				96				
INPUT																								
PO													400			240			480					
IV																								
NGt																								
TOTAL																								
OUTPUT																								
urine												100	250	50	150	50	200	275	100	50	50	125		
NGt																								
stool																								
TOTAL																								
NCE																								

MEDCOM - 12766

PATIENT ASS ENT [redacted] b(6)-2 ENT ASSESSMENT

TIME: 0047 SIGNATURE: [redacted] TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES	
Skin: Loose / Tight / Diaphoretic / Shiny / Dry	Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature 98.5	Skin: Temperature
Color: Pale / Cyanotic / Jaundiced normal for race	Color: Pale / Cyanotic / Jaundiced
Mucous Membranes: Moist / Dry / Cracked	Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: buttocks Size: quarter size	Skin Breakdown: None Location: Size:
NEUROLOGICAL	**NEUROLOGICAL**
Loc / Alert / Lethargic / Unresponsive GCS:	Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: PERL	Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None amputated (R) leg	Extremity Movement: Full / Limited / None
CARDIOVASCULAR	**CARDIOVASCULAR**
Pulse (0 - 4): + Radials + Pedals (R) foot	Pulse (0 - 4): Radials Pedals
Capillary Refill: good Seconds <3 Homan's Sign	Capillary Refill: Seconds Homan's Sign
Jugular Venous Distension Edema Ø	Jugular Venous Distension Edema
Heart Sounds normal	Heart Sounds
Rhythm normal PRI: QRS:	Rhythm PRI: QRS:
Vascular Catheter Central Arterial Peripheral 1 Peripheral 2	Vascular Catheter Central Arterial Peripheral 1 Peripheral 2
Waveforms	Waveforms
Site picline to (R) arm	Site
Solution Heparin	Solution
Chest Pain Lt lrs + Fade Both	Chest Pain
RESPIRATORY	**RESPIRATORY**
Chest Expansion / Symmetrical / Asymmetrical	Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles	Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: normal	Breathing Patterns:
Cough: Productive / Nonproductive / None	Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor Ø	Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:	Chest Drainage System Gravity: Suction cm.
Air Leak No Yes Crepitus	Air Leak No Yes Crepitus
Character of Drainage:	Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)	Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:	Artificial Airway Size: Type: Position:
Breath Sounds / Anterior/Location / Posterior/Location	Breath Sounds / Anterior/Location / Posterior/Location
Crackles	Crackles
Wheezes CTA	Wheezes
Diminished	Diminished
Absent	Absent
GASTROINTESTINAL	**GASTROINTESTINAL**
Abdomen: Soft / Firm / Hard / Distended cm Girth	Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings:	Dressings:
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage	NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character	NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:	Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character Ø	Stool: Character
Drains:	Drains:
GENITOURINARY	**GENITOURINARY**
Urine Color: yellow Character: clear	Urine Color: Character:
Voiding: Continent / Incontinent / Catheter	Voiding: Continent / Incontinent / Catheter
EMOTIONAL/PSYCHOSOCIAL	**EMOTIONAL/PSYCHOSOCIAL**
OTHER:	OTHER:

b(6)-4

FPW # [redacted] MEDCOM - 12767 JUL 16, 2003

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	108/56				0667	117/71	115/70																	
Temp	98.5					97.8	98.1																	
HR	75					80	80																	
RR	10					6	8																	
SAO2	97					100	100																	
O2						6L	RA																	
INPUT																								
PO																								
LR IV	125	125	125			125	125																	
NGt																								
IVPB		50	100																					
Fent	15	15	15																					
TOTAL																								
Output																								
urine		825					775																	
NGt																								
Stool																								
TOTAL																								
BALANCE																								

TO OR

Returned from OR

July 16, 2003

FPW #[redacted]

MEDCOM - 12768

b(6)-4

[redacted]

13 July 03

b(6)-2 All

PATIENT ASSESSMENT

TIME 0545 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm to touch - 98.6

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full Limited / None amputated RLeg

CARDIOVASCULAR

Pulse (0 - 4): + Radials + Pedals

Capillary Refill: good Seconds Homan's Sign

Jugular Venous Distension Edema Ø

Heart Sounds normal

Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			L arm	
Solution			LRC 125cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor white (thick whi

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	to Rt Mbl	
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains

GENITOURINARY

Urine Color: yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: pain management

PATIENT ASSESSMENT

TIME: 2000 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced Normal to Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds < 3 Homan's Sign −

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2 No Ectopy

Rhythm Sinus Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			(L) arm	
Solution			LRC @ 125cc/hr	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Ø Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Ø Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Drsg to (R) stump CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains: Ø

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

(E) 13 July 03

PT'S NAME [redacted]

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	108/59		112/63		130/79	117/61			94/69	85/48		92/48	92/48	95/48				100/69				105/54		
TEMP	98.6		98.7		94.9					97.7		97.7									98.2			
HR	70		82		126	68			77	88		69	69	67				83				63		
RR	12		10		18	10			9	8		8	8	8				11				13		
SA02	99		100		99	98			99	100		98	98	100				98				97		
														RA				RA				RA		
INPUT																								
PO																								
IV	125	125	125		125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT		50	100																					
ent					25	25	25	25	25	25	25	25	25	25	10	10	10	10	10	10	8	7	7	
IVPB																		200						
TOTAL																								
OUTPUT																								
URINE		500					1000													1000				
NGT																								
STOOL																								
TOTAL												1500												
BALANCE																								

1500
5

TO OR RETURN

MEDCOM - 12770

b(u)-2

PATIENT ASSESSMENT

TIME: 0530 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin Temperature 99°

Color: Pale / Cyanotic / Jaundiced Normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERL

Extremity Movement: Full / Limited / None Amputated RB leg

CARDIOVASCULAR

Pulse (0 - 4): + Radials + Pedals (LL) foot

Capillary Refill: good Seconds <3 Homan's Sign

Jugular Venous Distension Edema 0

Heart Sounds Normal

Rhythm Regular PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			LU arm	LU arm
Solution				LU @125cc/hr Rent

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal

Cough: Productive / Nonproductive / None white/clear

Sputum: Color / Amount / Consistency / Odor clear, scant, thin, 0

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	↓ @ lobe	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains

GENITOURINARY

Urine Color: yellow Character:

Voiding: Continent Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER: Drsg to RB stump.

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin Temperature warm

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive easily aroused

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials (+) Pedals (+)

Capillary Refill: < 3 Seconds Homan's Sign

Jugular Venous Distension 0 Edema 0

Heart Sounds S1 S2 NSR 68-70

Rhythm NSR PRI: pacer QRS:

Vascular Catheter	Central	Arterial	Peripheral	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain 0

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: regular non labored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor 0

Chest Drainage System Gravity: 0 Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished	↓ lower lobe	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: (R) stump

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character:

Voiding: Continent Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Cooperative, verbalizes need

OTHER:

PT'S NAME EPW [redacted] 14 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	112/70				112/68				114/60			118/70		97/53	109/51	104/54	103/50			94/49				107/56
TEMP	99.0				99.1				98.5			99.7		99.6	98.7					98.3				99.0
HR	79				86				60			88		88	92	83	105	59	67	64			70	68
RR	16				19				12			19		28	23	16	10	13	10	13			13	19
SA02	100				99				99			98		98	98	97	100	99	99	98			99	98
Mode	RA				RA				RA			RA		RA	RA	RA	RA	RA	RA	RA			RA	RA
INPUT																								
PO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	Pan-op									
LR IV	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NGT																								
IVPB		50		100						50														
TAL																								
TPUT																								
URINE	775			500			875			470						125								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

3000

2745

255

Tolerance (+255)

MEDCOM - 12772

PATIENT ASSESSMENT b(6)-2 [redacted]

TIME: 0500 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm & dry to touch

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERL 3+

Extremity Movement: Full / Limited / None Amputated (R) leg

CARDIOVASCULAR

Pulse (0 - 4): Radials (B) + Pedals (B) +

Capillary Refill: Good Seconds Homan's Sign

Jugular Venous Distension N/A Edema N/A

Heart Sounds normal

Rhythm T6-normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			Rt. arm	H. arm
Solution			LR@125cc/hr	LR@125cc/hr

Chest Pain Ø (Infiltrated)

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal - H

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: N/A Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE

SKIN AND MUCOUS M

Skin: Loose / Tight / Diaphoretic / Shiny

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Norm

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds <3 Homan's Sign (-)

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2 Noectopy

Rhythm Sinus Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site			(L) arm	
Solution			LR@125cc/hr	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Ø Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished	Bilat	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Drsg to (R) stump COI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain.

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

12 July 03

b(6)-4th [redacted]

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
		96.8		99				98.3			98.5								97.7				98.1
		81		88				117			86				86				70				73
		5		16				10			18				19				19				16
		100		98				100			100				99				100				100
	56	108/74		97/55				99/55			99/55				110/51				97/49				114/64
INPUT																							
PO	NPO	NPO			360	360	360		120						60			100					
IV	125	1250	125	125	125	125	125	125	120	125	125	125	125	125	125	125	125	125	125	125	125	125	125
NG+																							
IVPB		150		100				50									150						
Fent	15	15	–	–	–	–	–	–															
TOTAL												3055											
OUTPUT																							
urine						800		800	1025			750				675			600				
NGT																							
stool																							
TOTAL												2625											
BALANCE												+ 750 3375											

IN 6[illegible]
OUT 7[illegible]

MEDCOM - 12774

[redacted]
12 July 03

b(6)-2

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature 99.3 Axillary

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None ~~x~~ Right Lower Extremity

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 x2 Pedals +3 x1 (L)

Capillary Refill: ≤3 sec Seconds Homan's Sign neg

Jugular Venous Distension None Edema None

Heart Sounds S_1S_2 CTA

Rhythm NSR @ 79 BPM PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) arm	
Solution			LR @ 50cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion: Symmetrical / Asymmetrical

Respiration: No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg @ 24

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended non distended Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains JP

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ATIENT ASSESSMENT

TIME: 1700 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature WARM

Color: Pale / Cyanotic / Jaundiced Membranes pink

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Palp Radials +3 Pedals (L) palpable (R) Equivocal

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema

Heart Sounds S_1S_2

Rhythm SR HR 80's PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site			(R) FA	
Solution			LR 150°	

Chest Pain Denies

RESPIRATORY

Chest Expansion: Symmetrical / Asymmetrical

Respiration: No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Regular RR 20's

Cough: Productive / Nonproductive / None Ø to CDB

Sputum: Color / Amount / Consistency / Odor White

Chest Drainage System Gravity: Ø Suction cm.

Air Leak No Yes Crepitus

Character of Drainage: –

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	B, LAT
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: (L) BKA c̄ Ace wrap

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains: Ø

GENITOURINARY

Urine Color: yellow Character: dark

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

NO c/o discomfort @ present

OTHER:

11 July 03

b(6)-2 # [redacted]

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
Temp	99.3			97.9			98.5					101.3		98.6				99		98.7		99.2		99.4
HR	79			73			91					106		80	73	89		73		86		90		83
RR	24			16			15					15		13	13	21		21		19		16		14
SAO2	97%			98%			98%					98%		98				99		97		99		99
BP	104/52			101/52			104/57					124/73		107/67	103/62	104/59		101/62		107/61		119/71		105/61
INPUT																								
PO				NPO	→																			
IV	50	50	50	50	50	50	50	50				650	125	125	125	125	125	125	125	150	150	150	150	150 = 27
NGt								400				1050												
Feric														20	20	20	X	20	20	15	15	15	15	15 = 17
IVPB																100	100							20
TOTAL	50	100	150	200	250	300	350	400				1050	1175											input 3100 total
OUTPUT																								output 2400
urine						500												950				950		
NGT																								
STOOL						⊕																		
TOTAL																								
BALANCE																								1925

Pt OR for surgery — Pt returned from OR See OR Flow Sheet — See PACU Sheet for Post op Vitals

MEDCOM - 12776

Dr. # [redacted] 11 July 03

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature Warm

Color Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRL

Extremity Movement: Full / Limited / None (R) BKA

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +0

Capillary Refill: bt; sk Seconds Homan's Sign

Jugular Venous Distension Ø Edema ØNtd

Heart Sounds S1, S2

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg. R+R

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished	bilat	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Cast to (R) LE Stump

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character No BM

Drains: JP to (R) LE

GENITOURINARY

Urine Color: Clr Yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locati
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Draina

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

[redacted] 10 July

	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
Temp	97.7		97.2		98.2		98.3		98.6	99.5						101.5		100.9	X			99.2	
HR	71		68		72		91		93	71									80				
RR	16		14		16		16		18	23									20				
SAO2	98%		98%		97%		98%		97%	97									100				
BP	91/50		83/48		73/53		96/58		92/50	99/50								99/55	X				
INPUT																							
PO	450			400	240				240					200		100							
IV	50	125	50	50	1000	25	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	100
NGt																							
IVPb	100				100				50														
TOTAL																							
OUTPUT																							
urine				1050					925							950							
NGt																							
STOO																							
TOTAL																							
BALANCE																							
IS	✓									X		X		X		X		X					

IV 2275

PO 1730

Urine 2925

1080

MEDCOM - 12778

PATIENT ASSESSMENT

b(4)-2

TIME: 0630 SIGNATU [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None (R) BKA

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +2

Capillary Refill: brisk Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø Ntd

Heart Sounds S1, S2

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion: Symmetrical / Asymmetrical

Respiration: No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg. R+R

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea: Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA bilat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Cast to (R) stump

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains JP to (R) leg

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: Perrla

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds <3 Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site			Warm	
Solution			LR @ 50cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion: Symmetrical / Asymmetrical

Respiration: No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Ø Suction cm

Air Leak No Yes Crepitus

Character of Drainage:

Trachea: Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Ø Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locati
Crackles		
Wheezes	CTA Bilat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Cast to stump

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character Ø

Drains: JP Drain to (R) leg

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

09 Jul 03

[redacted] b(4)-4

EPW [redacted] b(a)-4

9 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
Temp		100.3	100.0	100.7		101.8		100.7		99.5		98.6		99.4				100.3		99.5		99.0		99.1
HR		102		96		106		100		96		84		83		96		94		87		83		80
RR		16		14		16		16		17		16		18		16		16		16		16		18
SaO2		98%		98%		96%		97%		98%		98%		98%		98%		97%		98		98		98%
BP		94/52		98/50		107/55		98/56		122/39				96/50		89/44		98/51		100/60		95/61		94/49
INPUT																								
PO		240		480																				
LR IV	50	50	50	50	50	50	5	1000	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
NG+																								
FEN+	17.5	17.5	17.5	15	15	10	10	10	5	5														
IVPB			50			100												200						
TOTAL																								
OUTPUT																								
urine											1075				800									
NGT																								
~~stool~~																								
JP											45cc													
TOTAL																								
BALANCE																								

MEDCOM - 12780

PATIENT ASSESSMENT

TIME: 8 July 07 SIGNATURE: [redacted] 2-(e)-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin Temperature warm 100.6
Color: Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None X RLE Amputation

CARDIOVASCULAR

Pulse (0 - 4): Radials ++ Pedals ++ in C
Capillary Refill: ≤ 3 Seconds Homan's Sign
Jugular Venous Distension None Edema None
Heart Sounds S S2
Rhythm NSR 88 bpm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			R arm	
Solution			LR @ 100	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: 14
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate:
Stool: Character
Drains

GENITOURINARY

Urine Color: Clear Yellow Character: QS
Voiding: Continent / Foley Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color: Pale / Cyanotic / Jaundiced Normal For Race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils:
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals X1 +2
Capillary Refill: Seconds ≤3 Homan's Sign
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1 S2
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			R Arm	
Solution			LR @50	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: RRR 16 BPM
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm
Air Leak No Yes Crepitus
Character of Drainage:
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: CDI
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:

GENITOURINARY

Urine Color: yellow Character: clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PT'S NAME: 85-0103

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	98/60					105/52		120/65		127/79		118/62		120/72		117/68		100/61		105/55		101/61		97/5
TEMP	100.6					99.3		99.8		103.4	104.3	102.3		100.5		100.6								
HR	89	See OR FlowSheet				101		101		136		110		105		110		111		111		99		103
RR	12					24		12		16		14		16		18		18		18		18		16
SA02	94					100		98		96		96		97		97		96		97		99		99
						RA		RA		RA		RA		RA		RA		RA		RA		RA		RA
INPUT																								
PO	~~0~~					0																		
IV	117.5	117.5				68	68	68	68	118	68	68	70	70	70	70	70	170	110	70	70	80	70	70
NGT						~~100~~																		
TOTAL	117.5																							
OUTPUT																								
URINE	~~0~~					300		200		300			300							1000				
NGT																								
STOOL																								
TOTAL						300		500		800			1100											
BALANCE																								

MEDCOM - 12782

EPW [redacted]

b(w)-2

PATIENT ASSESSMENT

TIME: 0600 SIGNATURE: [redacted] LTE/L

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm 98.8

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None x RLE Amputation

CARDIOVASCULAR

Pulse (0 - 4): L 3sec. Radials R (+) --- Pedals L (+)

Capillary Refill: ≤3 Seconds Homan's Sign ∅

Jugular Venous Distension NO Edema NO

Heart Sounds S1 S2

Rhythm NSR 71 PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms	N/A			
Site			R wrm	
Solution			LR @ 50 ml/hr	

Chest Pain None

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: R

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor non productive

Chest Drainage System Gravity: N/A Suction cm:

Air Leak No Yes --- Crepitus

Character of Drainage:

Trachea Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: RA Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	Clear bilateral	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage N/A

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character ∅

Drains ∅

GENITOURINARY

Urine Color: Yellow Character: Clear - Sediment

Voiding Continent / Foley Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature WNL

Color: Pale / Cyanotic / Jaundiced WNL

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3 mm

Extremity Movement: Full / Limited / None (R) BKA

CARDIOVASCULAR

Pulse (0 - 4): +3 Radials +3 Pedals +3

Capillary Refill: < Seconds 3 Homan's Sign (-)

Jugular Venous Distension (-) Edema -0

Heart Sounds S1 S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) Arm PIV	
Solution			Heparin	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: WNL

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: — Type: — Position: —

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA x all lung fields	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: —

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character None this shift

Drains:

GENITOURINARY

Urine Color: Amber Character: Clear

Voiding: Continent / Foley Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

EPW [redacted] 7 July 03

PTS NAME

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	121/77		109/71		116/67		122/71		116/65	106/45	100/60		98/57		97/59		108/68		103/64		107/69		102/65	
TEMP	96.8		98.7		100.3 (a)		101.9 (a)		101.2 (a)	100.8 (a)	99.2 (a)		97.8		98.1		99.8		98.7		99.2		100.8	
HR	71		71		74		84		97	102	86		68	S	83		93		89		96	85	83	
RR	12		11		13		14		15	16	18		16		12		18		17		19		10	
SA02	99		97		96		95		96	95	98		98		93		97		95%		96%		95	
	RA		RA		RA		RA		RA	RA	RA		RA		RA		RA		RA		RA		RA	
INPUT																								
PO														4000		350		200		100	NPO			
IV/R	50	50	50	50	50	50	50	Heplock																
NGT																								
Hanyl	30	30	30	30	30	30	30	20	30	20	30	30	30	30	30	30	30	30	30	30	30	30	30	30
IVPB		100	100					100		100														
TOTAL	80	260	240	500	800	880	960	1080	1110	1230	1260	1290	1320	1830	1860	1890	1920	1950	1980	2110	2240	2370	2500	2630
													480											
OUTPUT																								1600
URINE	0	0	0	900	100		400	625	650	375		350	350											
NGT																								
STOOL																								
TOTAL				900	1000		1400	2025	2675	2050		3400	3750											5350

F[redacted]E

2675
375
3050

MEDCOM - 12784

PATIENT ASSESSMENT EPW [redacted] b(6)-4 6JU/03

TIME: SIGNATU.

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry WNL

Skin : Temperature warm

Color: Pale / Cyanotic / Jaundiced Normal For Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None X RLE

CARDIOVASCULAR

Pulse (0 - 4): 52 Radials ++ --- Pedals +

Capillary Refill: ≤ 3sec Seconds Homan's Sign

Jugular Venous Distension None Edema None

Heart Sounds S, S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) ARM	
Solution			Hep locked	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes -- Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	CTA
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI to R leg

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains

GENITOURINARY

Urine Color: Character:

Voiding: Continent / urinal Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER.

PATIENT ASSESSMENT b(6)-2

TIME: 2/0c SIGNATUR[redacted]

SKIN AND MUCOU[redacted]MBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds ≤ 3 Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms				
Site			(R) arm	
Solution			UR @ 50cc/h	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Ø Suction cm

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Ø Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locati
Crackles	Clear Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: (R) Leg Bulky dressing & ace wrap

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drain

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PTS NAME EPW [redacted] Date 6 Jul 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	
BP	110/60				106/57				115/58				103/54				125/72	116/71	119/75	126/92	125/78	126/75	116/74	124/76	
TEMP	98.1				97.7				97.9				98.3				99.1		98.5						
HR	52				56				55				57				69	79	95	105	82	72	67	71	
RR	18				17				18				18				12	9	11	23	10	12	12	12	
SA02	96				97%				97%				97%				99	95	96	100	97	94	96	95	
					RA				RA				RA				RA	RA	RA	RA	RA	RA	RA	RA	
														IN OR											
INPUT																									
PO	NPO															50	50	50	50	50	50	50	50	50	450
IV UR					100					NG															
NGT																20	30	35	30	30	30	30	30	30	265
Dial																									
TOTAL																									
OUTPUT																									
URINE	200	400	100	200	200	0/200	600	200	0/100	0/100	0/100	100/100	900	900		200	100	100	100	100	200	100	100	200	2
NGT																									
STOOL																									
TOTAL																									
E CE																									

210
55
265

MEDCOM - 12786

EPW [redacted] b(6)-4 3 JULY 03

PATIENT ASS[redacted]ENT

ME: 0600 SIGNATUR[redacted] b(6)-2

SKIN AND MUCOUS ME[redacted]

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature warm

Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Breakdown: None Location: Size:

NEUROLOGICAL

Alert / Lethargic / Unresponsive GCS: 15

Orientated / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals

Capillary Refill: <3 sec Seconds Homan's Sign

Jugular Venous Distension Edema Ø

Heart Sounds S1 S2

Rhythm Reg PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(U)AC	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA Bilaterally	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended NPO cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: light yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

interacts c staff & gesture viz interpreter

OTHER:

SKIN AND MUCOUS [redacted]MBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal to Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm

Extremity Movement: Full / Limited / None ↓ RLE

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds <3 Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2 Ø Cardiopathy

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Pe
Waveforms				
Site			Hyperarm	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Mu

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/
Crackles	CTA	
Wheezes	Bilat	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girt

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: RLE - kerlex & ACE wrap

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: As

Stool: Character Ø

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

EPW [redacted] b(3)-4 5 July 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02
BP	101/65							170/~~70~~						120/66						150/60		
Temp	98.4							98						98						98		
HR	55							58						60						62		
RR	17							18						16						16		
SaO2	97							94						95						96		
								RA						RA						RA		
INPUT																						
PO																		110				
IV																		106				
NG+																						
TOTAL																						
OUTPUT																						
urine	300														200			300				
NG+																						
stool																						
TOTAL																						
NCE																						

MEDCOM - 12788

3 July 03 b(6)-2

PATIENT ASSES[redacted]

TIME: 0600 SIGNATUR[redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm PERRL

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds >3 Homan's Sign

Jugular Venous Distension ∅ Edema ∅

Heart Sounds S1 S2

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site				
Solution				

Chest Pain ∅

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Reg. Rate Rhythm

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor ∅

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: N/A Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: ORIF (R) Lower Ext.

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: NA Strength: Rate: Aspirate:

Stool: Character None

Drains:

GENITOURINARY

Urine Color: yellow Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Resting in bed ∅ S/S of Pain or discomfort

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRL 3mm

Extremity Movement: Full / Limited / None RLE in External Fix

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: Seconds <3sec Homan's Sign

Jugular Venous Distension None Edema

Heart Sounds S1 S2

Rhythm RR + PRIn PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			HL to	
Solution			NS	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RR + PRIn

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: N/A Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA Bilat	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: ORIF (R) LE

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character NONE

Drains:

GENITOURINARY

Urine Color: Clear Yellow Character:

Voiding: Continent / Incontinent / Catheter To gravity

EMOTIONAL/PSYCHOSOCIAL

Appears to be resting peacefully

OTHER: RLE elevated

PT'S NAME:

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP		114/70						115/63						132/51					110/51					
TEMP		98.6						98.3						98.7					98.5					
HR		65						70						69					62					
RR		20						17						14					16					
SA02		97						96						98					97					
INPUT																								
PO				250		200			500							240								
IV				50						50														
NGT																								
TOTAL																								
OUTPUT																								
URINE						700			600			900						700					300	
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 12790

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 16 17 18 19 20 21

19 | HOUR

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

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

O2 sat

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

REGISTER NO.

WARD NO. ICW 2

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

I 511 (REV. 7-95)
VICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 19 | DAY: 22, 23, 24, 25, 26, 27, 28 | HOUR

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

TEMP. F	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

PULSE (O)
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 1CW2

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

[redacted]

b(6)-4

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August DAY 6 7

19 HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE 120/80 120/80 120/80

HEIGHT: WEIGHT → 98 98% 98% 98% 98%

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

[redacted]

b(6) - 4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR July 03 — August

DAY: 29, 30, 31, 1, 2, 3, 4, 5

HOUR: 19

PULSE (O) — TEMP. F (°) — TEMP. C (Centigrade Equivalents, for Reference only)

TEMP. F (°)	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

PULSE: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD — RR

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

EPW# [redacted]

b(6) -4

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM	HOURS	TOTAL HOURS COVERED	DATE
TO 0859	HOURS	24 0	19JUL

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

JP Drain ~~IRRIGATIONS~~ (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0430	Bloody drainage	100cc	100cc
2100		20 cc	50cc
0800	light red	6.5	36.5 cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
					18JUL03

~~NASOGASTRIC~~ JP Drain

TIME	AMOUNT	TYPE	ACCUM TOTAL
2030	30cc	Bloody	30

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)*

EPW

[redacted] 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

Ward/Section: EMT

[redacted] b(6)-2

ISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

b(6)-4 LAST, FIRST, M: [redacted]

DATE: 15 JUL 03 TIME: 2300 SSN/PSEUDO-SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	2.9	3.5-5.5 g/dl
ALP	74	26-84 u/l
ALT	24	10-47 u/l
AMY	77	14-97 u/l
AST	24	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	8.6	8.0-10.3mg/dl
CHOL	132	100-200 mg/dl
CRE	0.8	0.6-1.2 mg/dl
GLU	83	73-118 mg/dl
TP	6.2	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	81	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	131	39-380 u/l (M) 30-190 u/l (F)
NA^+	131	128-145 mmol/l
K^+	4.1	3.3-4.7 mmol/l
CL^-	105	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB	~~2.9~~	3.3-5.5 g/dl
ALP	~~74~~	26-84 u/l
ALT	~~24~~	10-47 u/l
AMY	~~77~~	14-97 u/l
AST	~~24~~	11-38 u/l
TBIL	~~0.7~~	0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

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

DATE: 21 Jul 03

LAB ID NO.:

d/Section: RMJ | RE[redacted]NG PHYSICIAN: [redacted] b(6)-2 | RATORY RESULT FORM (Subject to the Privacy Act of 1974)

ST, FIRST MI [redacted] b(6)-4 | DATE 1JUL03 | TIME 2300 | SSN/PSEUDO SSN: [redacted] b(6)-4

Hematology/CBC

EST	RESULT	REF. RANGE
WBC	9.0	4.8-10.8 x 10^3
RBC	3.88	4.7-6.1 x 10^9
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.1	42-52% (M) 37-47% (F)
MCV	90.2	80-94 fl (M) 81-99 fl (F)
plt	210	130-500 x 10^3 verified
Lymph %	36.3	20.5-51.1%

Hematology/Manual Differential

s		Mono	
ds		Eos	
mph		Baso	
p		Imm	
C ph			

n natocrit		42-52% (M) 37-47% (F)
Rate		
er		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
TT		21-34 secs
imer		<20 ug/ml
		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

MARKS:

PORTED BY [redacted] b(6)-2 | DATE: [redacted] b(6)-4 | LAB ID NO.:

ICU 3 b(6)-4 Dr [redacted] b(6)-2 # [redacted] b(6)-4

EPW [redacted]

7 July 0405

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. R
WBC	11.9	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	3.90	4.7-6.1 x 10^9	App		N/A	Mono		Negative
	11.1	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
	35.2	42-52% (M) 37-47% (F)	Bili		Negative	Source		
	90.3	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
	576	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negati
Lymph %	19.7	20.5-51.1%	Bld		Negative	H. pylori		Negati
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
		Imm	Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			
Hct Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WI EVERY UNIT REQUESTE		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank (Bmc Crossmatch) (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATC
PT		9.8-13.6 secs			
aPTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] b(6)-2

b(4)-2

Ward/Section: ICU3	ING PHYSICIAN: [redacted]	ORY RESULT FORM (...o the Privacy Act of 1974)
LAST, FIRST, MI: b(4)-4 [redacted]	DATE: 8 Jul	TIME: 0500	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.5	4.8-10.8 x 10^3
RBC	4.03	4.7-6.1 x 10^6
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.3	42-52% (M) 37-47% (F)
MCV	90.3	80-94 fl (M) 81-99 fl (F)
Plt	482	130-500 x 10^3 verified
Lymph %	19.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE:	LAB ID NO.:

b(4)-2

Chemistry Only

Ward/Section: 1C03

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

CHEMISTRY RESULT FO
(Subject to the Privacy Act of 197

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

DATE: 25Jul03 TIME: 0325 SSN/PSEUDO SSN: [redacted] b(6)-4

STAT

TEST	RESULT	REF. RANGE
Na	133	138-146 mmol/L
K	4.9	3.5-4.9 mmol/L
Cl	97	98-109 mmol/L
pH	7.498	7.31-7.45
pCO2	40.8	35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
tCO2	33	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	~~32~~	22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	4	8-26 mg/dl
GLU	105	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

Chemistry

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

Triglycerides

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

Pseudo Metabolic Panel

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

Pseudo Liver Panel Plus

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

Pseudo Electrolyte

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

REMARKS:

28 25Jul03

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted] b(6)-4	DATE: 9 July	TIME: 0400	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	17.8	4.8-10.8 x 10^3
RBC	3.06	4.7-6.1 x 10^9
Hgb	8.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.3	42-52% (M) 37-47% (F)
MCV	91.0	80-94 fl (M) 81-99 fl (F)
Plt	416	130-500 x 10^3 verified
Lymph %	16.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted] b(6)-2

REPORTED BY: [redacted] **DATE:** **LAB ID NO.:**

Ward/Section: ICU-3	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. #[redacted] b(6)-4	DATE 09JUL	TIME 1525	SSN/PSEUDO-SSN #[redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1005	N/A
Bld	Neg	Negative
pH	6.5	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 9 JUL 09	LAB ID NO.:

b(6)-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 10JUL4 / TIME 0335	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

Chemistry Only

Ward/Section: ICU 3

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

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

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

DATE: 10JUL4 TIME: 0335 SSN/PSEUDO SSN: [redacted] b(6)-4

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

Hepatic Panel

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

[redacted]

TEST	RESULT	REF. RANGE
GLU	114	73-118 mg/dl
BUN	6	7-22 mg/dl
CRE	0.4	0.6-1.2 mg/dl
CK	952	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	3.9	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	28	18-33 mmol/l

Glucose & Metabolic Panel

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

Renal Function Panel

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

[redacted]

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

REMARKS:

b(6)-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 10Jul03	TIME 1035	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

Ward/Section: CW3	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. H [redacted] b(6)-4	DATE 11 Jul	TIME 0330	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	11.1	4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

Ward/Section: ICU3	RE[redacted]ING PHYSICIAN: b(6)-2	LA[redacted]TORY RESULT FORM (Su[redacted] to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 EPW [redacted]	DATE: 0400 / TIME: 12Jul	SSN/PSEUDO SSN: EPW [redacted] b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU #3	RE	ING PHYSICIAN: [redacted] b(6)-2	LA TORY RESULT FORM (Su to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]		DATE: 13JUL4	TIME: 0330	SSN/PSEUDO SSN: [redacted] b(6)-4

b(6)-2

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted]	**DATE:**	**LAB ID NO.:**

b(6)-2

ICU 3

b(6)-4

EPW [redacted]

b(6)-2

Dr [redacted] 14July 0230

b(6)-4 [redacted]

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	8.6	4.8-10.8 x 10^3
RBC	2.55	4.7-6.1 x 10^9
[illegible]	7.0	14-18 g/dl (M) 12-16 g/dl (F)
[illegible]	22.6	42-52% (M) 37-47% (F)
[illegible]	88.6	80-94 fl (M) 81-99 fl (F)
[illegible]	611	130-500 x 10^3 verified
Lymph %	25.6	20.5-51.1%

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Metamyelo		Baso	
[illegible]		Imm	
[illegible]			
[illegible]			
Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

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

Blood Bank Unit Crossmatch (MUST SUBMIT SF518 WITH EVERY UNIT OF BLOOD REQUESTED)		
UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] DATE: LAB ID NO.

b(6)-2

Chemistry Only

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted]	DATE 7/15/03	TIME 0330	SSN/PSEUDO SSN:

b(6)-2

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

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

Acute Metabolic Panel

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

Liver Function Panel

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

Electrolyte Panel

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

REMARKS:

[redacted] 15 Jul 03

b(6)-2

b(6)-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 EPW [redacted]	DATE: 7/15/03 TIME: 0330	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE:	LAB ID NO.:

b(6)-2

b(6)-2

Ward/Section	R[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
ICU-3	DK [redacted]	
LAST, FIRST, MI: b(6)-4 # [redacted]	DATE: 15 Jul	TIME: 1610
		SSN/PSEUDO SSN: # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 15 Jul 03	LAB ID NO.:

b(6)-2

b(4)-2

Ward/Section: ICU 3	REQ[redacted]NG PHYSICIAN: [redacted]	LABO[redacted]ORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M[redacted] b(4)-4	DATE 16 Jan	TIME 0430	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC,		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted]	DATE: 16 Jan 03	LAB ID NO.:

b(4)-2

Ward Section: 1CW2

REQU 5 PHYSICIAN:

CHEM RY RESULT FORM
(Subject to the Privacy Act of 1974)

AST. FIRST. MI: EPW # [redacted] b(6)-9

DATE: 18Jul03 TIME: 0355 SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF RANGE
Na	133	138-146 mmol/L
K	4.2	3.8-4.9 mmol/L
Cl	100	98-109 mmol/L
pH		7.31-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
tCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN	6	8-26 mg/dl
GLU	147	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]

DATE:

LAB ID NO.:

b(6)-2 18Jul03

1CW2 b(6)-4 [redacted] 2LT IAN

EPW # [redacted] b(6)-4

18JUL03 [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		150-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 18Jul03 **LAB ID NO.:**

b(6)-2

b(6)-2

Ward/Section: ICW2	REQUESTING PHYSICIAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: EPW# [redacted] b(6)-4	DATE: 4Aug03	TIME: [redacted]	SSN/PSEUDO SSN: 0376

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
ASOA	(Mg)	10 – 10
Benadryl	(Mg)	50
Versed	(Mg)	2.5
Propofol	(Mg)	50
	( )	
Robinul	(Mg)	.2
VOLAT AGENT: ISO	% del	X/1.5/1.5/1.5/1.5/.8/1.4/X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8/3/3/3/4/4/4/8

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

FLUIDS — LINE site: 18g RUE — ☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed — CRI ——— 80 – 100

LOSSES — EST BLOOD LOSS; URINE – Foley, indwelling 200

TOTALS	
20	TOTAL FLUID: <100
50	
2.5	TOTAL URINE: 200
50	
.2	

FLUIDS – SUMMARY: CRYSTALLOID 100 LR; COLLOID – Ø; BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

1340 PT ID, Ø CHANGE FROM PREOP Hx
1350 Rm. O2, MON.
1359 TOPS
1508 LPT TO SPC [redacted]

VITS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT:

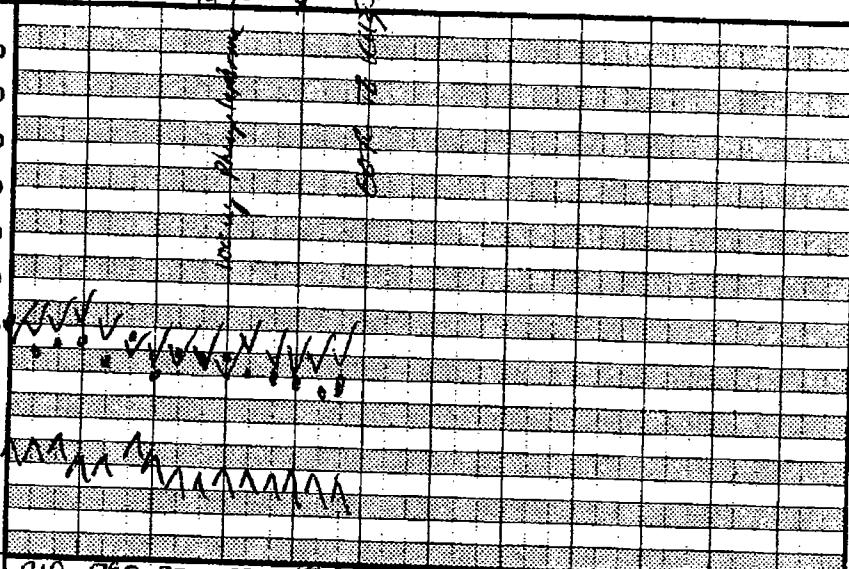
INITIAL DATA: BP – 93/52; HR – 100

EQUIP CHECK: OK? – (Y) N

PATIENT TROUBLE: OK for PROCEDURE? Y; TIME – 1357

TIME → 1345, 1400, X, 1420, X, 1500

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



MONITORS / RECORDS		1345	1400		1420		1500
	VT – ml	710	790	370	250	530	
	f – breaths/min	16	16	16	16	12	
	Peak inf pres / PEEP	/	/	/	/	/	
	M(O)DE – S(pon), A(ssist), C(on)	S	S	S	S	S	
✓ BP/Auto Cuff	✓ ET CO2 (torr)	41	38	39	39	40	
✓ BP / oth	✓ FIO2 (Frac or %)	.75	.75	.75	.75	.70	
✓ ART line	✓ SpO2 (%)	100	100	100	100	100	
✓ Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	
✓ Gas analyzer	✓ TEMP- site	Avail					
	✓ N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS

EVENTS — Position → O-J

RECOVERY AT 1504; PACU ICU ____ (Specify); OTHER ____; CONDITION: STABLE; RESP – ; SpO2 – ; BP – ; HR –

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1340	1350	1510
	Ready	Begin	End
PROC	1359	1428	1452

PROCEDURES and CPT Codes: EXT FIX ADJUSTMENT

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA – mask

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: MASK C NA

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

SURGEONS: [redacted] b(6)-2

PROCEDURE LOCATION: OR 1 — 3 JUL 03

NKA
P.V / Foley

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	(mg)	2.5
Fentanyl	(cc)	1 2 1 1
Propofol	(mg)	20/130 20
Succ	(mg)	90
Mencyan	(mg)	12.5
MSO4	( )	5 5
VOLAT AGENT Fen	% del	X1 - .8 - 1 — 1.5 - 2 — 2-1.5 0.X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 - 3 - 2 — 2 - 2 - 3 - 2 4

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

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

FLUIDS		
LINE site RA 18g	☐ Warmed	— 400 - 700 - 800 900 1000 LR →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	250/250 150/150

TOTALS	
25 mg	
250 mcg	
TOTAL IN	150
TOTAL URINE	250

FLUIDS – SUMMARY
CRYSTALLOID – LR / NS 1000
COLLOID – 0
BLOOD – 0

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 65 KG LB

HEMATOCRIT:

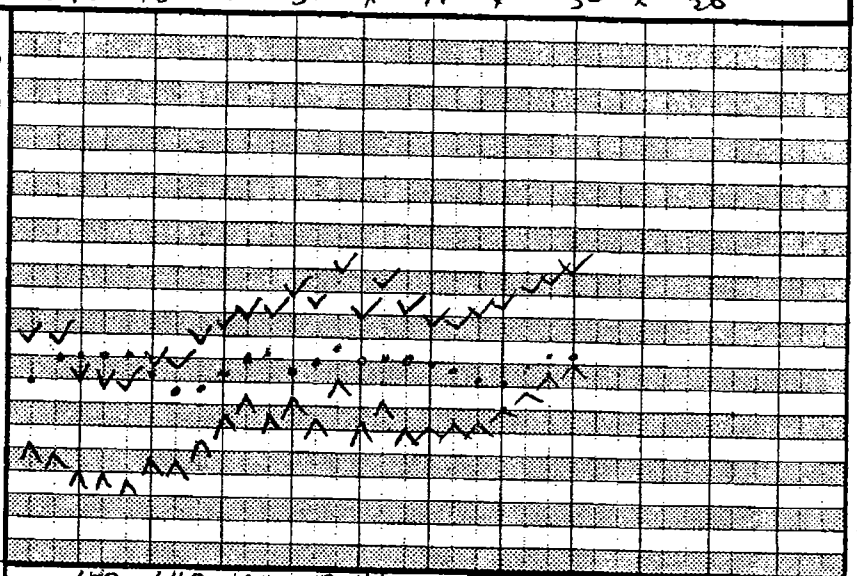
INITIAL DATA: BP – 94/153 HR – 96 77 %

SUPP CHECK: OK? – ✓ N

PATIENT RECHECK: OK for PROCEDURE ✓ TIME – 1730

TIME → 1745 1800 x 30 x 15 x 30 x 20

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



MONITORS & MACHINES									
VT – ml		640	640	660	650	660	560		
f – breaths/min		8	7	7	7	8	6	12	12
Peak inf pres / PEEP		18	18	18	18	17	16		
MODE – S(pont), A(ssist), C(on)		S C	C	C	C	C	C	S	S
BP/Auto Cuff	Y ET CO2 (torr)	31	32	32	33	32	34	34	
BP / oth	Y FIO2 (Frac or %)	.88	.81	.89	.83	.88	.88	.88	
ART line	Y SpO2 (%)	100	100	100	100	100	100	100	
Steth- PC/ES	Y ECG	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer	Y TEMP- site P.E.	36.5	36.1	36.9	36.9	37.1	36.9°C	X	
	Y N-M Block (T/4)	4 0 4							
Warming blkt									
Conv warmer									

Report to [redacted]

Mark with letters & symbols, explain under REMARKS

EVENTS Position →

REMARKS – Code drugs with numbers, events with letters

Prep PIV ✓ NSO
given 1200 agree
to GA for R leg amp
Cooperative to OR
On monitors Stth
IV induction
FX FIX d/c prep/drape
1937 Incision, Agreed to E.

RLR T @ 2.0 cm 14
↑ @ 1812
↓ @ 1845
33 min T.T.

RECOVERY AT
PACU ICU 3 (Specify)
OTHER
CONDITION: STABLE
RESP – 16 Room Air SpO2 – 99
BP – 127/84 HR – 103

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1725	1735	1945
	Ready	Begin	End
PROC	1742	1754	1935

PROCEDURES and CPT Codes
Rt BKA

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA: eyes taped, DLX1, gel I vein, 3 MAC, 8.0 ETT
BSS = 3, + BS < 0, tape @ 24 cm G.B.B.

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

DCU #3

#[redacted]

b(6)-4

[redacted] ATC
CRNA

b(6)-2

PROCEDURE LOCATION OR 1

6 JUL 03

1 of 1

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)							
Versed	(mg)	5						
Ephed	(mg)	50	50	50	25	25	25	25
propofol	(mg)	150					50	
Lidg	(mg)	25					25	
MS04	( )		5		5			
	( )							
HOLAT AGENT	Forane % del		15	20	15	1	X	
	% e.t.							
AIR	L/Min							
N2O	L/Min							
O2	L/Min	8	2	2	2	3	9	

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

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

TOTALS	
5 mg	
250 mg	150
	TOTAL URINE
10 mg	350

FLUIDS – SUMMARY
CRYSTALLOID– 1300
COLLOID– Ø
BLOOD– Ø

FLUIDS							
LINE site LR	☐ Warmed		500	800		1300	
	☐ Warmed						
	☐ Warmed						
	☐ Warmed						
LOSSES	EST BLOOD LOSS		100	150			
	URINE –		300	350			

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 65 KG (LB)

HEMATOCRIT: 35.2

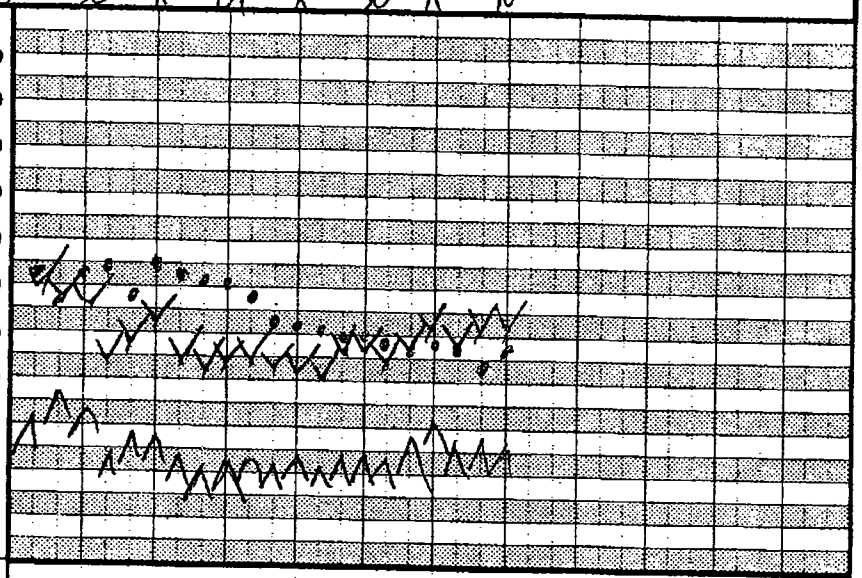
INITIAL DATA: BP – 120/64 HR– 124

CORP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME– 0730

TIME → X 30 X 09 X 30 X 10

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



VT – ml								
f – breaths/min	12	10	6	12	6	9	9	7
Peak inf pres / PEEP								
MODE– S(pon), A(ssist), C(on)	SV	AV	SV	SV	AV	SV	SV	SV
ET CO2 (torr)		48		47	46	39	37	41
FIO2 (Frac or %)	93	92	91	91	91	91	91	
SpO2 (%)	97	98	95	100	100	100	100	92
ECG	ST	ST	ST	ST	ST	ST	ST	ST
TEMP- site	Available							
N-M Block (T/4)								

MONITORS / ACCESSORIES: BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

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

REMARKS–
Code drugs with numbers, events with letters

0815 in OR monitors applied

0820 Induct # 4 LMA placed ⊕ Dilat BS ⊕ ETCO2

1005 Spont Resp ⊕ Swallow, LMA out transfered to ICU stable report given.

RECOVERY AT 100
PACU ICU ICU3 (Specify)
OTHER
CONDITION: RA
RESP– 12 SpO2– 94%
BP– 115/85 HR– 118

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	0715	0815	1020
PROC	Ready	Begin	End
	0820	0836	1000 0955

PROCEDURES and CPT Codes
(L) BKA Revision @ washout

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Gen Anes #4 LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments #4 LMA placed one attempt ⊕ ETCO2 ⊕ Dilat BS

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

[redacted] ICU3 ICU3
b(6)-4

SURGEON [redacted]
b(6)-2

PROCEDURE LOCATION OR 2
28 inch

MAJ CRNA 7/8/03

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	30	9
Versed	(mg)	2.5	
Fent	(ug)	50	50
Propofol	( )	180	
	( )		
	( )		
	( )		
VOLAT AGENT	Fo vaporizer % del	1.2	1 X
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	4	

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

FLUIDS

LINE site	
LR start 2-700	Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES

EST BLOOD LOSS	
URINE -	

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 105 KG LB

HEMATOCRIT: 25

INITIAL DATA:

BP- 118/69

HR- 87

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME- 0730

TIME → 08 90

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	
f - breaths/min	
Peak inf pres / PEEP	
MODE - S(pon), A(ssist), C(on)	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)
BP/oth	FIO2 (Frac or %)
ART line	SpO2 (%)
Steth- PC/ES	ECG
Gas analyzer	TEMP-site Axillary
	N-M Block (T/4)
Warming blkt	
Conv warmer	

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

TOTALS 1.5 / 250 cc — **TOTAL EBL** 10

TOTAL URINE UM

FLUIDS - SUMMARY

CRYSTALLOID- 150 cc/hr

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

1 Time in
2 BP 104
Anesthesia
O2 88

RECOVERY AT

PACU ICU 3 (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR- 17

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0715	0755	0855
	Ready	**Begin**	**End**
PROC	0805	810	845

PROCEDURES and CPT Codes:

I&D (R) Leg Abscess

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

#4LMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #4LMA

Placed on e attempt (+) ETCO2 (+) Bilat BS b2-2

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] CRNA [redacted]

PROCEDURE LOCATION: [redacted]

DATE: 7/13/03

PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
phenergan	(mg)	12.5 12.5
Morphine	(mg)	4/2 4/4 6
propofol	(mg)	150
	( )	
	( )	
	( )	
VOLAT AGENT Ess	% del	2.0 1.5 1.5 1.0X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 – 2 – 2 – 2 – 2 6

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

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

LINE site 20g RFA ☐ Warmed — RL 800↑ — 500–600
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES — EST BLOOD LOSS
URINE –

TOTALS — TOTAL TIME: 20 min
TOTAL URINE: None

FLUIDS SUMMARY
CRYSTALLOID– 600
COLLOID– Ø
BLOOD– Ø

REMARKS – Code drugs with numbers, events with letters

(1) To room, soc. mons applied, pre O_2.
(2) Smooth IV ind.
(3) Pt to recovery stable. Report to nsg staff.

ASA STATUS: (2) 3 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 26

INITIAL DATA: 103, 59 — 102

BLOOD CHECK: K? (Y) N

PATIENT RECHECK: for PROCEDURE? Y

ALLERGIES –

TIME → 13 30 14 30 15 30

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	450	400	410	500	470	
f – breaths/min	28	34	28	24	26	
Peak inf pres / PEEP						
MODE– S(pon) A(ssist) C(on)	S	S	S	S	S	S
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	30	30	30	32	34	
✓ BP / oth / ✓ FIO2 (Frac or %)	0.8	0.8	0.8	0.8	0.8	
✓ ART line / ✓ SpO2 (%)	ST	ST	ST	ST	ST	ST
✓ Steth- PC/ES / ✓ ECG	100	100	100	100	100	100
Gas analyzer / TEMP- site available						
N-M Block (T/4)						
Warming blkt						
Conv warmer						

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

RECOVERY AT: PACU (ICU) 3 (Specify) OTHER

CONDITION: RESP– 16 SpO2– 98 BP– 127/79 HR– 105

	TIMES / PROCEDURE TIME		
ANES	Start	Room	End
	1300	1310	1425
PROC	Ready	Begin	End
	1315	1325	1410

PROCEDURES and CPT Codes: Debride/Washout Rt BKA Stump

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Gen Mask

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes taped, #4 OA placed, easy mask

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

b(6)-4

EPW [redacted]
24 yo ♂
NKDA
IW 3

SURGEO[redacted]

[redacted] MAS, CRNA

WAM[redacted] REVISED 1 Jan 99

b(6)-2

PROCEDURE LOCATION 1-1
DATE 7/11/03
PAGE 1 OF 1

PATIENT RECORD

☆ U.S. GPO: 1999 – 528-336/10

ICU 3

Drawer Cart

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS		
DRUG	(Mg/kg)	
Propofol	(ml)	70
MSO4 (10)	(ml)	10 5 5
Lidocaine	(ml)	50
VC 3cc	(ml)	2
VOLAT AGENT: Hal	% del	1.3 1.6 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 - 2 - 10

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

FLUIDS		
LINE site 14 (R)	☐ Warmed	1L ——— 200
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	Wet measured

TOTALS	
70	
30	
5	
2	
TOTAL FLUID	m.h
TOTAL URINE	N/A

FLUIDS SUMMARY	
CRYSTALLOID–	200
COLLOID–	Ø
BLOOD–	Ø

REMARKS – Code drugs with numbers, events with letters

0535 Pt. c.o. ICU 3. Given 10mg MSO4 titrated. To OR via litter – Pt moved self.
0600 In room. ⊕ monitors, ⊕ O2, smooth IV/inhalation induction, Arms < 90° on armboards.
0616 Procedure started
0640 Procedure completed. To ICU 3 in stable condition, Report to RNs.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 65 KG LB

HEMATOCRIT: 7.4/24

INITIAL DATA: BP – 106,56 HR – 75

EQUIP CHECK: OK? – Y N

PATIENT REQUEST: OK for PROCEDURE – Okay TIME – 0530

TIME → 0600 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL		
VT – ml	–	– –
f – breaths/min	24	30 24
Peak inf pres / PEEP	–	– –
MODE– S(pon), A(ssist), C(on)	S	S S

MONITORS/ACCESSORIES				
BP/Auto Cuff	ET CO2 (torr)	31	28	30
BP / oth	FIO2 (Frac or %)	>.21	>.21	>.21
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	SR	ST	SR
Gas analyzer	TEMP- site			
	N-M Block (T/4)			
Warming blkt		Pt pulled, eyes taped, nose free of pressure		
Conv warmer				

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

RECOVERY AT 0645	
PACU ICU 3 (Specify)	
OTHER	
CONDITION: Stable	
RESP – 12	SpO2 – 100
BP – 103/66	HR – 90

TIMES	Start	Room	End
ANES	0535	0600	0648
PROC	Ready 0608	Begin 0616	End 0640

PROCEDURES and CPT Codes: Washout (R) BKA Stump

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Anesthesia mask, oral airway, Eyes taped.

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

ICU 3

b(6)-4 [redacted]

EPW

NKDA 24 yoo

SURGEONS [redacted] b(6)-2

ANESTHETIST [redacted]

PROCEDURE LOCATION: OR 1

DATE: 12 Jul 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

☆ U.S. GPO: 1999 – 628-336/10085

6 Changes Box 13 July 03 8.6 Hgb 22.6 Procedure verified

Pre-op done 13 July 03

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)													
lidocaine (MG)	30												
Propofol (MG)	200												
Sux (MG)	100												
MS04 (MG)	<10>	<10>											
( )													
( )													
VOLAT AGENT 150 % del		1.5	1.5	1.5	X								
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	6	2	2	2	10								

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

FLUIDS

LINE site													
☐ Warmed	LR												
☐ Warmed													
☐ Warmed													
☐ Warmed													

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 22

INITIAL DATA: BP- 118/70; HR- 88

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? (Y); TIME- 1700

TIME → 1700 X 1800 X 30 X 1900

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

HDC Corporation — REF: 380-55 — Description: 4.0Fr Single Lumen PICC — LOT: 1108 — PATIENT CHARGE

VENTIL

VT - ml		650	590	300
f - breaths/min		10	30	20
Peak inf pres / PEEP		17		
MODE - S(pon), A(ssist), C(on)	SV	CV	SV	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		32	32	
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	0.80
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	SR
Gas analyzer	TEMP-site	Skin	35		
	N-M Block (T/4)				
Warming blkt	head wrap				
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → d - arms < 90° abducted & padded

TOTALS: 30, 200, 100, 20 — **TOTAL EBL**: MIN — **TOTAL URINE**: Ø

FLUIDS - SUMMARY: CRYSTALLOID- LR-500; COLLOID- Ø; BLOOD- Ø

REMARKS (Code drugs with numbers, events with letters)

1700 - A met & chart reviewed NPO place

1840 - Pt sedated monitors on induction & intubation look over for cons PICC line placed using aseptic technique advanced to 50cm - 10cm mark, Ø pulsing + Blood return

1950 Pt suctioned RR > 8 + < 30 BPM TV > 4mL/kg Extubated & Complications TO ICU-3 Report

RECOVERY AT 1927

PACU ICU 3 (Specify)

OTHER T 96 Ax

CONDITION: Stable

RESP- 20 SpO2- 98

BP 94/47 HR- 115

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1800	1840	1940
	Ready	Begin	End
PROC	1850	1900	1915

PROCEDURES and CPT Codes: D&D (R) BKA stump.

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

[redacted]

b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: #2 Miller, taped 2 Cm teeth. OGT & Bed ETT-LSE. Eyes taped. OGT & Foley return

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 P penny. Gt 1 w/ease. ETT easily passed BBS+/ECG + A Remarks

SURGEON: [redacted] b(6)-2

ANES: [redacted]

PROCEDURE #

LOCATION:

DATE: 14 July 03

PAGE 1 of 1

DA FORM 7389, FEB 1998 — MEDCOM - 12824 — COPY [redacted] PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD - ANESTHESIA

For us[illegible] his form, see AR 40-66; the proponent agency i[illegible] OTSG

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

DRUG	(Units)														
Fentanyl	(mcg)	<250>													
Versed	(mg)	10		<10>											
Propofol	(g)	150													
Neosynephrine	(mcg)			100		100									
Zofran	(mg)														
	( )														
VOLAT AGENT	Sevo % del	2.0	3.5	2.0	3.0	2.0 X									
	% e.t.														
AIR	L/Min														
N2O	L/Min														
O2	L/Min	10	2	2	2	2	10								

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → X Heparin 5000

FLUIDS

LINE site			
17G R PIV	☐ Warmed	LR	
(L) AC	☐ Warmed		
	☐ Warmed		
	☐ Warmed		

LOSSES

EST BLOOD LOSS	
URINE -	Not measured

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 22

INITIAL DATA:

BP- /

HR- 90

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE?

TIME- 0650

TIME → 0700 . 30 . 0800 15

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

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

VENTIL

VT - ml	T	600	560	410	600
f - breaths/min	—	10	10	14	15
Peak inf pres / PEEP	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	40	35	37	31	35
BP/oth	FIO2 (Frac or %)	0.83	0.83	.83	.83	.83
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR			ST	SR
Gas analyzer	TEMP-site	Axilla	Skin	34		
	N-M Block (T/4)					
Warming blkt	x1 Blanket					
Conv warmer						

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

TOTALS	TOTAL EBL
250	200cc
20	

TOTAL URINE: NA

FLUIDS SUMMARY

CRYSTALLOID- 400

COLLOID- 200

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

0650 - Pre-induction of anesthesia: IV PO verified; Lungs CTA (B) CV RRR (-) m

0700 Room, mask O2 mask

0715 Chris Walters called to relieve.

0810 To ICU 3 in stable condition, to ICU 3 c̄ mask O2. Report to RN

RECOVERY AT 0815

PACU ICU 3 (Specify)

OTHER

CONDITION: Stable

RESP- 16 SpO2- 100

BP- 111/66 HR- 71

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0645	0700	0820
	Ready	Begin	End
PROC	0714	0723	0808

PROCEDURES and CPT Codes: I&D (R) BKA

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GMA

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

#[redacted]

b(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Patent trachea left

SURGEONS: [redacted] b(6)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION: 1

DATE: 15 July 03

PAGE 1 OF

DA FORM 7389, FEB 1998

MEDCOM - 12825

[redacted]T'S MEDICAL RECORD

USAPA V1.00

ICU3

MEDICAL RECORD - ANESTHESIA

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

Drawer Case

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

DRUG	(Units)																		
Lidocaine	(mg)	50																	
Versed	(mg)	5																	
Ansay	(mg)	10	10	10															
Propofol	(mg)	140																	
	( )																		
	( )																		
VOLAT AGENT Halothane	% del		1.3	1.8	1.5	1.0	X												
	% e.t.																		
AIR	L/Min																		
N2O	L/Min																		
O2	L/Min	10	2	2	2	2	10												

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

FLUIDS

LINE site																		
(L) AC PICC	☐ Warmed	(800cc)																(500)
	☐ Warmed																	
	☐ Warmed																	
	☐ Warmed																	

LOSSES: EST BLOOD LOSS; URINE - Not measured

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 65 KG LB

HEMATOCRIT: 8/24

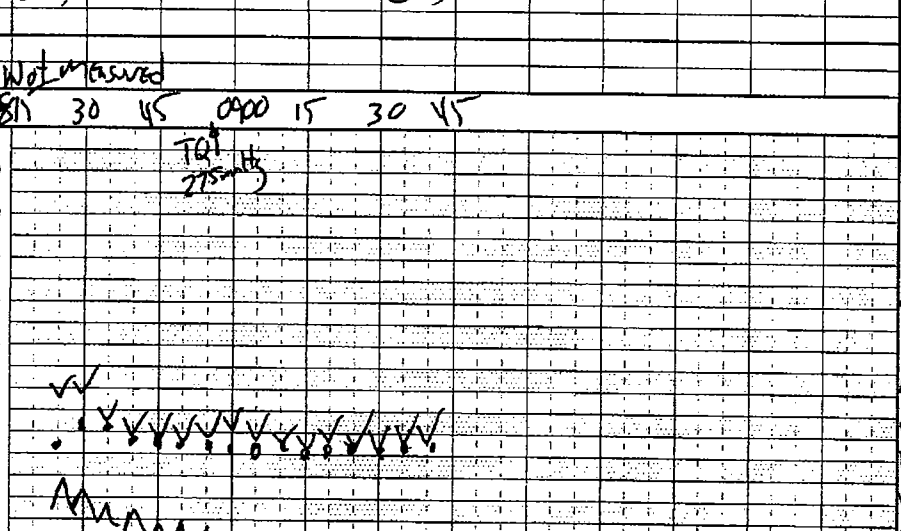
INITIAL DATA: BP- ___/___ HR-

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Okay TIME- 0815

TIME 0815 30 45 0900 15 30 45

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



VENTIL

	0815	30	45	0900	15	30	45
VT - ml	—	—	—	—	—	—	
f - breaths/min	20	22	16	18	18	16	
Peak inf pres / PEEP	—	—	—	—	—	—	
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S	

MONITORS/ACCESSORIES

		0815	30	45	0900	15	30	45
X BP/Auto Cuff	X ET CO2 (torr)	(+)	40	43	45	4		
BP/oth	FIO2 (Frac or %)	.91	.91	.91	.91	.91	.91	
ART line	X SpO2 (%)	100	100	100	100	100	100	
Steth- PC/ES	X ECG	SR	ST	SR	SR	SR	SR	
Gas analyzer	X TEMP-site skin							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

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

TOTALS	TOTAL EBL
50	100
5	
30	TOTAL URINE
	W/A

FLUIDS - SUMMARY
CRYSTALLOID- 500
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters.
0810 Arrived in ICU 3. To OR via litter, O2 on. 0820 In room, ⊕ monitors, ⊕ O2. Smooth IV induction. Pt padded, eyes taped. Airway L 90°. 0846 Procedure started. 0840 LMA out's diff. Oral Airway, NT placed. Pt vent easily. 0845 To ICU 3 c̄ mask c̄ O2, stable, Report to RN.

RECOVERY AT 0945
PACU ICU 3 (Specify)
OTHER
CONDITION: Stable
RESP- 15 SpO2- 100
BP- 117/71 HR- 43

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0810	0820	0835
PROC	Ready 0835	Begin 0846	End 0910

PROCEDURES and CPT Codes: TKD (R) BKA

ANESTHETIC TECHNIQUES: GA

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

EPW [redacted]

b(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments #4 LMA inserted X 1 attempt c̄ difficulty, ⊕ BBS ⊕ ETCO2 Soft tissue

SURGEON [redacted]

ANESTHE[redacted] b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 16 Jul 03

PAGE 1 OF 1

See previous pre-op & As

WKDA

MEDICAL RECORD - ANESTHESI

For us .ais form, see AR 40-66; the proponent agency , OTSG

Procedure verified

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION																		
DRUG	(Units)																	
Lidocaine	(Mg)	30																
Propofol	(Mg)	200																
MSO4	(Mg)	10	10	10	10													
	( )																	
	( )																	
	( )																	
VOLAT AGENT	5.0 % del	2.0	1.5	1.25	X													
	% e.t.																	
AIR	L/Min																	
N2O	L/Min																	
O2	L/Min	6	2	2	2	6												
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →		induction																

FLUIDS																		
LINE site #20	☐ Warmed	LRT																
B/A	☐ Warmed																	
	☐ Warmed																	
	☐ Warmed																	
LOSSES	EST BLOOD LOSS																	
	URINE -																	

TOTALS	TOTAL/EBL
	—
40 mL	TOTAL URINE
	—

FLUIDS - SUMMARY
CRYSTALLOID- 600
COLLOID- —
BLOOD- —

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 65 (KG / LB)

HEMATOCRIT: 24.6

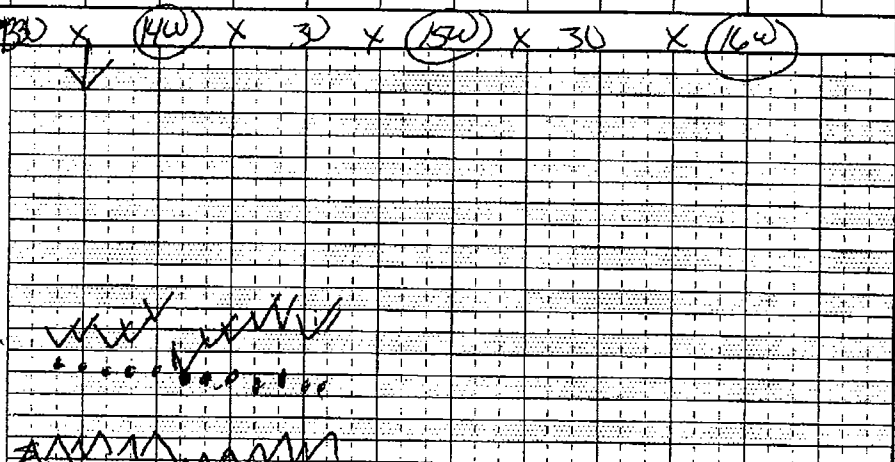
INITIAL DATA: BP- 108/56 HR- 75

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? (+) TIME- 135

TIME → 130 x (140) x 30 x (150) x 30 x (160)

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



VENTIL						
VT - ml			200	200	350	350
f - breaths/min		20	23	23	21	21
Peak inf pres / PEEP						
MODE - S(pon), A(ssist), C(on)		SV	SV	SV	SV	SV
MONITORS/ACCESSORIES						
BP/Auto Cuff	ET CO2 (torr)		35	35	35	36
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	NS	NS
Gas analyzer CO2	TEMP-site	unavailable				
	N-M Block (T/4)					
Warming blkt	Wool blanket					
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → a — Cuff 90 inflated c padded

REMARKS
Code drugs with numbers, events with letters

1330 Meth
10 ml IV injection
Chart ved
Pre op done
1340 In room - monitors on induction
1345 Awake
LMA D/C
TO ICU for recovery
ICW2

RECOVERY AT: PACU (ICU) (Specify) OTHER STABLE
CONDITION: 35
RESP- 12 SpO2 97%
BP 116/66 HR- 116

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1330	1345	1445
	Ready	Begin	End
PROC	1350	1353	1420

PROCEDURES and CPT Codes: D&D (R) Stump

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: #4, 20 cm inserted to cuff, 1 Proud or Place c set bite block, Eyes taped General LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Preoxygenation. LMA #4 inserted. X-T attempt. Atraumatic

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

[redacted] ICW-2

b(6)-4

SURGEON: [redacted] b(6)-2

ANESTHETIST: [redacted]

PROCEDURE #1
LOCATION:
DATE: 17 Jul 03
PAGE 1 of 1

DA FORM 7389, FEB 1998

MEDCOM - 12827

COPY 1 - PATIENT'S MEDICAL RECORD

USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

Drawover Case

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

DRUG	(Units)																	
Versed	(mg)	<5>																
Fentanyl	(mcg)																	
MSO4	(mg)	<10>	<10>		<10>													
Propofol	(mg)		30															
	( )																	
	( )																	
VOLAT AGENT Halothane	% del	1.5	1.1	1.3	1.0	X												
	% e.t.																	
AIR	L/Min																	
N2O	L/Min																	
O2	L/Min	10	2	2	2	2	10											

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

TOTALS	TOTAL EBL
3	100cc
30	TOTAL URINE
	w/A

FLUIDS SUMMARY

CRYSTALLOID- NS 700cc

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site																		
20g (R) wrist	☐ Warmed	NS	—	—	(400)	—	(700)											
	☐ Warmed																	
	☐ Warmed																	
	☐ Warmed																	

LOSSES

EST BLOOD LOSS				50														
URINE -	Not measured																	

REMARKS

Code drugs with numbers, events with letters

7/18/03 No Δ in pt status since prior workup. Plan GA.
0720 Pt'd in ICW 2. To OR in litter.
0730 In room, ⊕ vitals, ⊕ O2. Smooth induction, intubation, c̄ drawover. Pt padded, eyes, ears, nose free of pressure
0855 Procedure complete. To ICW 2 c̄ mask O2. Stable, awake. Rep to RW

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 65 (KG) LB

HEMATOCRIT 24.6%

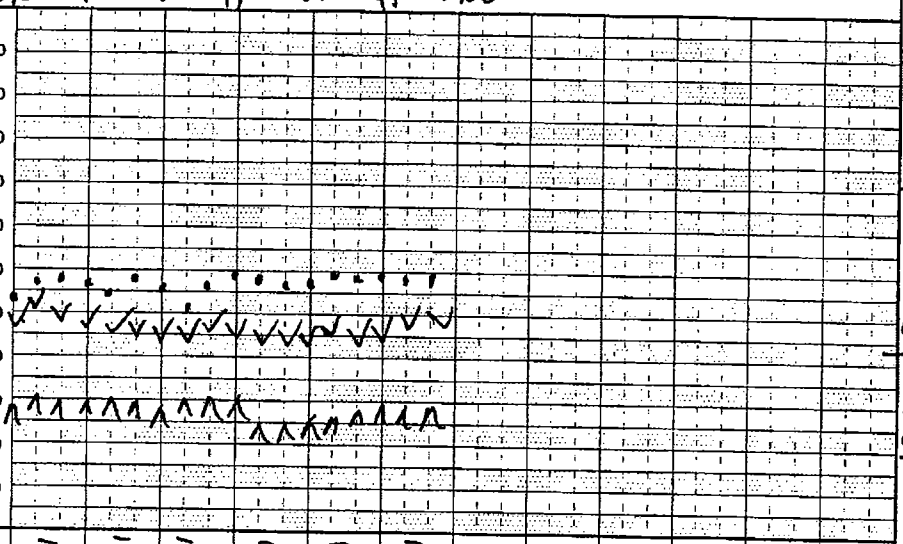
INITIAL DATA BP- 104/60 HR- 118

EQUIP CHECK OK?- (✓) N

PATIENT RECHECK OK for PROCEDURE? Okay TIME- 0715

TIME 0730 45 0800 15 30 45 0900

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



VENTIL

	0730	45	0800	15	30	45	0900
VT - ml	—	—	—	—	—	—	
f - breaths/min	18	30	31	30	24	24	
Peak inf pres / PEEP	—	—	—	—	—	—	
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S	

MONITORS/ACCESSORIES

		0730	45	0800	15	30	45	0900
BP/Auto Cuff	ET CO2 (torr)	⊕	32	33	34	36	36	
BP/oth	FIO2 (Frac or %)	>.21	>.21	>.21	>.21	>.21	>.21	
ART line	SpO2 (%)	100	100	100	100	100	100	
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	
Gas analyzer	TEMP-site Skin				96°			
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → a →

RECOVERY AT 0900

PACU ICU 2 (Specify)

OTHER

CONDITION: Stable

RESP. 24 SpO2- 100

BP- 99/71 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0720	0730	0900
	Ready	Begin	End
PROC	0740	0758	0855

PROCEDURES and CPT Codes: IrD (R) BKA - Closure Stump

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

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

EPW # [redacted]
24 yo ♂ b(6)-4
ICW 2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Anesthesia Mask, oral airway, Nasal Trumpet. Eyes taped.

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION:

DATE: 7/18/03

PAGE 1 OF 1

NKDA Smoker

® BKA drsg Δ vs AKA   General Anes.   MVC PI B/S CTA, HEENT ... SV, 5706 100/60

ASA II Tele Hx I&D, drsg Δ
NKA   last surg 18 ...

MEDICAL RECORD - ANESTHESIA

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

S: Gent 1800 F. Lovil Forty 0300

Prescott ... D. Mott ...

ANESTHETIC AGENTS AND DRUGS — DRUG (Units)				TOTALS
promethazine (mg)	25			25
morphine (mg)	<10> 4/2	4		20
propofol (mg)	140			
( )				
( )				
( )				
VOLAT AGENT Iso % del / % e.t.	1.5	X		
AIR L/Min				
N2O L/Min				
O2 L/Min	6-2-2X			
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	① ②	③		

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

TOTAL EBL: Ø
TOTAL URINE: N/A

FLUIDS - SUMMARY
CRYSTALLOID- 400
COLLOID- Ø
BLOOD- Ø

FLUIDS: LINE site 18g RAC ☐ Warmed — NS ——— 400
☐ Warmed
☐ Warmed
☐ Warmed

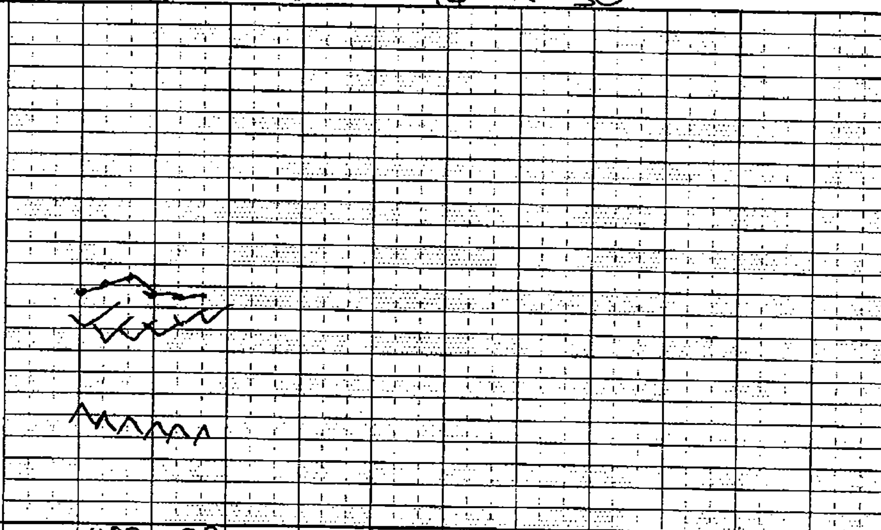
LOSSES: EST BLOOD LOSS / URINE -

REMARKS
Code drugs with numbers, events with letters
Pt's chart ✓. Labs ✓. OK to proceed c̄ GA.
① To room, SOC monitors on, preO2.
② Smooth IV induction.
③ To recovery stable. Report given.

PHYS STATUS: 1 ②345 E
BODY WEIGHT: 65 KG
HEMATOCRIT: 18 Jul 26.9
INITIAL DATA: BP- 91/58; HR- 107
EQUIP CHECK: OK?- Ⓨ/N
PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1430

TIME → 30 × 15 × 30 × 16 × 30

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



VENTIL		
VT - ml	400	390
f - breaths/min	26	20
Peak inf pres / PEEP	—	—
MODE - S(pon), A(ssist), C(on)	S	S

MONITORS/ACCESSORIES			
✓ BP/Auto Cuff	✓ ET CO2 (torr)	34	32
BP/oth	✓ FIO2 (Frac or %)	0.8	0.8
ART line	✓ SpO2 (%)	100	100
Steth- PC/ES	✓ ECG	ST	ST
Gas analyzer	TEMP-site available		
	N-M Block (T/4)		
Warming blkt			
Conv warmer			

RECOVERY AT 1512
PACU (ICU) (Specify)
OTHER 99°
CONDITION:
RESP- 21 SpO2- 100
BP- 92/59 HR- 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1430	1445	1520

	Ready	Begin	End
PROC	1450	1455	1510

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

PROCEDURES and CPT Codes:
EUA, remove JP, dsg Δ R+ BKA stump

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
General mask.

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] AKA FREDDY
b(6)-4 ICW 2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, 30F NA placed, easy mask

SURG[redacted] b(6)-2, MAJ, CRNA

PROCEDURE LOCATION: 1-1
DATE: 7/20/03
PAGE 1 OF 1

DA FORM 7389, FEB 1998   MEDCOM - 1[redacted] PATIENT'S MEDICAL RECORD   USAPA V1.00

Smoller NKDA

For ... s form, see AR 40-66; the proponent agency ·TSG

MEDICAL RECORD - ANESTHESIA

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

DRUG	(Units)													
Versed	(mg)	2-2												
MSO4	(mg)	10	4	6	5	5								
propofol	(mg)	50	50											
	( )													
	( )													
	( )													
VOLAT AGENT	halothane % e.t.	.5-1	.75	.75	.75	.75	.75	.5						
AIR	L/Min													
N2O	L/Min													
O2	L/Min	4-6	4	4	4	6	6	6						

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

FLUIDS

LINE site													
☐ Warmed													
IV LR ☐ Warmed			400				600						
☐ Warmed													
☐ Warmed													

LOSSES

EST BLOOD LOSS													
URINE -													

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 65 KG (LB)

HEMATOCRIT: 28.9

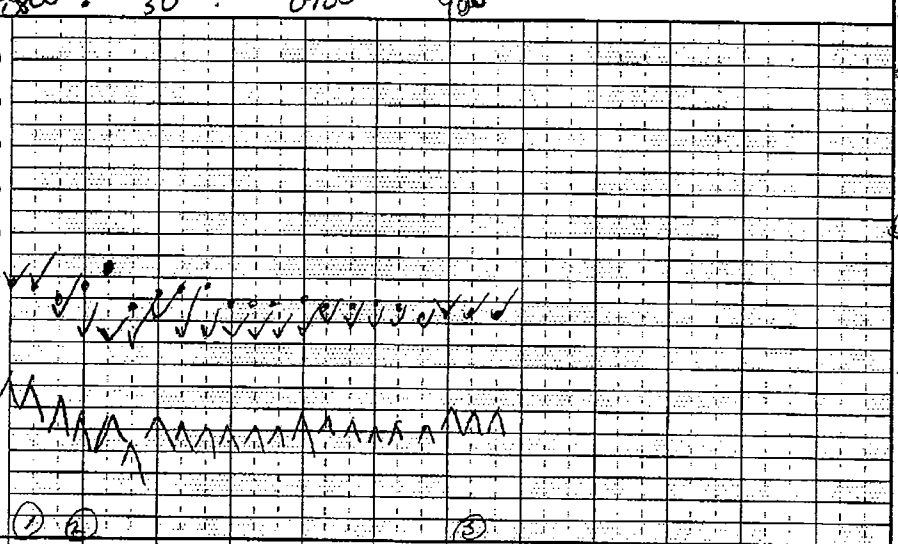
INITIAL DATA: BP- 113/79 HR- 118

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0730

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

TIME → 0800 · 30 · 0900 · 930



VENTIL

VT - ml								
f - breaths/min		32	36	22	22	22	22	22
Peak inf pres / PEEP								
MODE - S(pon), A(ssist), C(on)		S	A	S	S	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	42	43	45	42	45	45	45
BP/oth	✓ FIO2 (Frac or %)	.85	.85	.85	.85	.85	.85	.84
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100
✓ Steth- PC ES	✓ ECG	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	✓ TEMP-site Skin	34	34	34	34	34	34	34
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Bilat arms <90°

TOTALS 4mg, 30mg, 100mg

TOTAL EBL 60 cc

TOTAL URINE Ø

FLUIDS SUMMARY
CRYSTALLOID- 600 cc
COLLOID-
BLOOD-

REMARKS Code drugs with numbers, events with letters

PO'd pt in PACU
① Inhalation induction c halothane tolerated well
② OETT placed per surgeon
0906 end of Casting
③ To PACU 3 on Rm air 99% Responds to Name
Report to Capt Rajski RN
VS Stable.

RECOVERY AT 0945
PACU ICU 3 (Specify)
OTHER
CONDITION: Stable
RESP- 22 SpO2- 99
BP- 113/69 HR- 111

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0800	0945
	Ready	Begin	End
PROC	0818	0827	0937

PROCEDURES and CPT Codes:
(R) Stump closure with flap advancement

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Mask induction, oral airway → OETT 8.0 @ 22 cm +/= BBS + ETCO2

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR 1
DATE: 06 Aug 03
PAGE 1 OF 1

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

ESTHESIA PLAN OF CARE PRE...OCEDURAL ASSESSMENT (Sedation/A...esthesia)

24 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

POSED PROCEDURE: I&D (R) Tib & Ex Fix
GICAL SERVICE:
SINCE:

ASA Physical State (1) 2 3 4 5 E
WT: 65 (KG)/LB HT: 66? IN.
ALLERGIES: NKDA

ITS: SMOKER
BACCO: (1)
ETOH:
DRUGS:

RENT MEDICATIONS:
ordered as premed
Ancef

MEDICATIONS:
Yes (@ _____ Hrs) /CC
_____ mg IV IM PO
_____ mg IV IM PO
_____ mg IV IM PO

ORATORY STUDIES:
H/H
CT: 11.1 / 35.1
ER:

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Pulmonary System:
- Asthma N Y IN & EX WHEEZES
- Bronchitis/URI N Y
- COPD N Y (B)
- Other N Y

Renal System:
- Acute/Chronic RF N Y

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

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

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

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
I & D MULTIPLE

III PHYSICAL EXAMINATION
BP 51 HR 83 R 20 T
Pain Scale 0-10
HEENT - Teeth WNL
Trachea
TMJ/Neck 3+
Oropharnyx MP-2
Nares
CHEST: IN & EX WHEEZES
CARDIAC: S_1 S_2
EXTREMITIES:
IV Access: (R) FA
Ulnar Filling:
BACK:
OTHER:

NPO Since YESTERDAY

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

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to
cussed with the [redacted]dian. b(6)-2
patient/[redacted]and and agrees. Questions answered.
ned: [redacted] Date: 03 JUL 03 Time: 0720 Hrs

ST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ned: _____ Date: _____ Time: _____ Hrs

ent Identification: (Ward)

~~EPW #~~ [redacted]

~~Stays in ICU-1~~
~~Rec, in ICU-2~~

EPW # [redacted]
b(6)-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.

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

Age 2Y DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: BKA, (R) ly
SURGICAL SERVICE: ORTHO/GS
NPO SINCE: 1200

s/p ex fix

ASA Physical State (1) 2 3 4 5 E
WT: 65 (KG)/LB HT: 66 IN.
ALLERGIES: Ø

HABITS: ✓
TOBACCO:
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef
( ) Mody
( )
( ) Percocet
( )
( )

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
s/p ex fix

PHYSICAL EXAMINATION
BP 103/54 HR 57 R 17 T 98.3
Pain Scale 0-10 ____ 97% on RA
HEENT - Teeth OK
Trachea
TMJ/Neck MP Cl II
Oropharnyx 3/3 M-3
Nares
CHEST: CTA = B
CARDIAC: RRR
EXTREMITIES:
IV Access: RA PIV 18g
Ulnar Filling:
BACK:
OTHER:

NPO Since ____

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

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

b(6)-2

The patient/[redacted] seems to understand and agrees. Questions answered.

Signed: [redacted] Date: 6 JUL 03 Time: 1220 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ____

[redacted]

b(6)-4

ICU #3

STHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

24 DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 65 KG/LB HT: 66 IN.
ALLERGIES: NKDA

OSED PROCEDURE: BKA (L) leg
ICAL SERVICE: Ortho/GS
INCE: MD

S:
ACCO: (+)
ETOH: ø
RUGS: ø

ENT MEDICATIONS:
dered as premed

Ancef
Tagamet
Fluid IV
Versed

EDICATIONS:
/es (@ _____ Hrs) /CC
.. _____ mg IV IM PO
.. _____ mg IV IM PO
.. _____ mg IV IM PO

RATORY STUDIES:

:T: _____/_____

R: _____

133/97 | 4 < 105
49 | 40.8

11.9 > 11.1 / 35.2 < 576

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	See pre-op 6 July
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC

S/P ex Fx

PHYSICAL EXAMINATION

BP 90/60 HR 89 R 12 T 100.6
Pain Scale 0-10 _____
HEENT - Teeth poor dentition -
Trachea MP-2 3F Boval
TMJ/Neck IM 3FB
Oropharnyx _____
Nares _____
CHEST: RRR
CARDIAC: CTA
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

STHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ (X) General: Mask intubation

MED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to a sed with the patient/legal guardian. b(6)-2

[redacted] stand and agrees. Questions answered.

[redacted] Date: 7/8/03 Time: 0730 Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

: _____ Date: _____ Time: _____ Hrs

t Identification: (Ward) _____

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

ANESTHESIA PLAN OF CARE — ANESTHESIOLOGIST ASSESSMENT (Section) — Anesthesia

Age: 24 DAYS MOS YRS — Sex: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Washout — S/P GSW Rt tibia & Lt hand

SURGICAL SERVICE: Surgery

NPO SINCE: 0700

ASA Physical State: 1 2 3 4 5 E

WT: 65 (KG) LB HT: ___ IN

ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) LR 50cc/Hr
( ) Levaquin 500 q AM
( ) Colace 100mg BID
( )
( )
( )

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

LABORATORY STUDIES:

HB/HCT: ___/___
U/A:
OTHER:

11.1 / 8.3 / 525 / 26.2

130 | 101 | 6 / 114
3.9 | 28 | 0.4

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

all neg

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Rt BKA 6 July
Revision 8 July
Ex fix 2 June?

multiple easy intub.

PHYSICAL EXAMINATION
BP 104/59 HR 90 R 15 T 98.5
Pain Scale 0-10 sleeping
HEENT - Teeth poor
Trachea ML
TMJ/Neck FROM
Oropharnx: MP2
Nares N/A
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access: RFA 20g
Urine Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 0700

1310

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ___ (X) General: (Mask) Intubation GETA backup

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to [redacted] b(6)-2 discussed with [redacted] Questions answered.

Date: 7/11/03 Time: 1230 Hrs

POST-[redacted]
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ___ Date: ___ Time: ___ Hrs

No Δ in pH 7.4/58 X 7.4 23.9 for 7/12/03, [redacted] CPT CRNA b(6)-2

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

Patient Identification: (Ward) ICU 3

EPW # [redacted] b(6)-4

Plan for 1300 since pt ate bkft.

ANESTHESIA PLAN OF CARE | NOCICEPTIVAL ASSESSMENT (SEDATION) | ANESTHESIA

Age 24 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R) Amputated Leg IeD SP GSW R + Tibia & L + Hand
SURGICAL SERVICE: General
NPO SINCE: NN

ASA Physical State 1 (2) 3 4 5 E
WT: 65 KG/LB HT: ___ IN
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Vanco
( ) Levo
( ) Flagyl
( ) Ten. Heparin
( ) Tondol
( ) Tent

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

LABORATORY STUDIES:

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

6.7) 7.7 / 25 <594

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Neg
See PO
7/11/03

ASSESSMENT

PAST SURGICAL/ANESTHETIC
RAKA 6 Jul
Remission 8 Jul
Ex-lx 7 June

PHYSICAL EXAMINATION
BP 104/59 HR 70 R 12 T 98.6 ax
Pain Scale 0-10 ____
HEENT - Teeth Fractures poor Orpt Intact
Trachea MP Airway
TMJ/Neck 3 FB + TM
Oropharynx 3 FB Malpaning
Nares ____
CHEST: CTA JK base
CARDIAC: RRR
EXTREMITIES: ____
IV Access: ____
Urinary Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

Procedure pt understands: Inactalk & Extenpater

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to [redacted] discussed wit[redacted] legal guardian. b(6) 2

The p[redacted] and agrees. Questions answered.

Signed: [redacted] Date: 7/13/03 Time: 0730 Hrs

POST-AN[redacted] EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ICU3 - ICU3

EPW

[redacted]

b(6) - 4

37K

ANESTHESIA PLAN OF CARE P. | PROCEDURAL ASSESSMENT (Section [illegible])

Age ___ DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: (L) BKA Warhead
SURGICAL SERVICE: Gen Surg
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 E
WT: 65 KG/LB HT: ___ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (7)
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
! = ordered as premed

Vanco
Levaquin
Heparin
Felt
M 504

REMEDICATIONS:
one Yes (@ ___ Hrs) /CC
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ___/___
VA: ___
OTHER: ___

6.7 / 7.7 / 24.6 / 684

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System:
Acute/Chronic RF N Y

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

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

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y

Gynecological :
Pregnancy N Y

Other Significant Hx:
N Y (L) BKA
N Y 2 yr hx
Familial HX N Y 15 Jul

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Sprain -

PHYSICAL EXAMINATION
BP 108/86 HR 71 R 10 T 98.5
Pain Scale 0-10 ___
HEENT - Teeth Poor dentition
Trachea MP 2 3FB Oral
TMJ/Neck Mallpine
Oropharynx ___
Nares ___
CHEST: ___
CARDIAC: ___
EXTREMITIES: ___
IV Access: ___
Urinary Foley: ___
BACK: ___
OTHER: ___

NPO Since MN

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ___ (X) General: Mask Intubation

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

[redacted] b(6)-2

The p[redacted]stand and agrees. Questions answered.

Signe[redacted] Date: 7/16/03 Time: 0800 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

[redacted]

b(6)-4

SEDATION KEY:

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

376 ANESTHESIA PLAN OF CARE P: EPIDURAL ASSESSMENT (BASIC/ADVANCED)

Age ___ DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

PROPOSED PROCEDURE: (L) BKA warhood
SURGICAL SERVICE: Gen Surg
NPO SINCE: MN

ASA Physical State 1 (2) 3 4 5 E
WT: 65 KG/LB HT: ___ IN
ALLERGIES: NKDA

HABITS:
TOBACCO: (7)
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

Vanco
Levoquin
Heparin
Fent
MS04

PREMEDICATIONS:
Done Yes (@ ___ Hrs) /CC
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO

LABORATORY STUDIES:

CBC/HCT: ___/___
PTA: ___
OTHER: ___

6.7 > 7.7 / 24.6 < 684

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

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

Renal System:
Acute/Chronic RF N Y

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

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

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y

Gynecological:
Pregnancy N Y

Other Significant Hx:
N Y (L) BKA
N Y 24 YRS
Familial HX N Y 15 Jul

ASSESSMENT
PAST SURGICAL/ANESTHETIC
S/P ORIF

PHYSICAL EXAMINATION
BP 108/76 HR 77 R 10 T 98.5
Pain Scale 0-10 ___
HEENT - Teeth Poor dentition
Trachea MP 2 3FB Oral
TMJ/Neck Midline
Oropharynx ___
Nares ___
CHEST: ___
CARDIAC: ___
EXTREMITIES: ___
IV Access: ___
Urinary Foley: ___
BACK: ___
OTHER: ___

NPO Since MN

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ___ (X) General: Mask Intubation

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

The pa[redacted]erstand and agrees. Questions answered.

b(6)-2

Sig[redacted] Date: 7/16/03 Time: 0800 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

[redacted]

b(6)-4

SEDATION KEY:

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

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS: 1 Unit

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 15 JUL 03

DATE AND HOUR REQUIRED: NOW

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)*: DR [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P (R) BKA

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

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

DATE VERIFIED: 15 JUL 03

TIME VERIFIED: 1050

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO.

PATIENT NO.

DONOR ABO: A pos Rh

RECIPIENT ABO: A pos Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED [redacted] 03 b(6)-2

REMARKS: EXP: 15 JULY 03

SECTION III – RECORD OF TRANSFUSION

PRE-[redacted]SION DATA

INSPECTED AND [redacted] b(6)-2

AT *(Hour)* 1149 ON *(Date)* 15 JUL 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] LTC/AN b(6)-2

2nd VERIFIER *(Signature)* [redacted] SGM/MSC

TEMP. 98.5 PULSE 88 BP 96/57 91/50

DATE OF TRANSFUSION: 15 JUL 03

TIME STARTED: 1210

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME	DATE	COMPLETED	INTERRUPTED
1 Unit ML	1330	15 JUL 03		

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

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

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

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

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

[redacted] Male

WARD: ICU-3

[redacted] b(6)-4

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

MEDCOM - 12838

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 15 Jul 03

DATE AND HOUR REQUIRED: NOW

REQUESTING PHYSICIAN *(Print)*: DR [redacted] b(4)-2

DIAGNOS[redacted]ERATIVE PROCEDURE: S/P (R) BKA

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: [redacted] b(4)-2

REMARKS: 1 Unit

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

TIME VERIFIED: 15 Jul 03 1050

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(4)-4

[redacted]

TRANSFUSION NO.

PATIENT NO.

[redacted]

RECIPIENT

ABO A Rh pos

ABO A Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE [redacted]ING TEST: [redacted] b(4)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 15 JUL03

REMARKS: Exp: 15 JUL03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AN[redacted] b(4)-2

A[redacted]318 ON (Date) 15 July 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* b(4)-2

[redacted]

[redacted] 91W MG b(4)-2

PRE-TR[redacted]

TEMP. 98.5 PULSE 88 BP 121/53

DATE OF TRANSFUSION: 15 Jul 03

TIME STARTED: 1540

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

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 Unit ML

TIME DATE COMPLETED: 1520

INTERRUPTED

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

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

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

SIGNATURE OF PERSON NOTING ABOVE

[redacted]

SEX: Male

WARD: TCU-3

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
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#[redacted] b(4)-4

MEDICAL RECORD COPY

INSTRUCTIONS FOR NON SELF-EXPLANATORY ITEMS

SECTION I – REQUISITION

Component Requested

"Other (Specify)" – List any whole blood or blood product not on menu, i.e., washed RBC's, deglycerolized RBC's, etc.

"Volume Requested (If applicable)" – Use only when different from standard amount, i.e., exchange transfusion 50 ml.

"Known Antibody Formation/Transfusion Reaction" – Check Medical Records. Annotate N/A if appropriate.

"If Patient is Female, Is There History Of" – Check medical records. Annotate N/A if appropriate.

SECTION II – PRE-TRANSFUSION TESTING

"Transfusion Number/Patient Number" – List either based on local procedures.

"Previous Record Check" – Current tests should be compared with prior records for ABO and Rh type, difficulty in blood typing, clinically significant unexpected antibodies, and severe adverse reactions.

"Test Interpretation" – Use the following standard notations. "NEG" or "POS" for antibody screen block. "COMPAT" or "INCOMPAT" for crossmatch block.

SECTION III – RECORD OF TRANSFUSION

"Pre-Transfusion Data"

"Inspected and Issued by _____ at _____ on _____."
(Signature) (Hour) (Date)

This statement is to be completed by the issuing laboratory person once he/she has inspected the blood immediately before issue from the laboratory. The blood must not be abnormal in color or appearance or expired, and if any of these conditions exist the blood will not be used for transfusion.

"Signature" blank must contain the signature, as opposed to name, of issuing laboratory person.

"Hour" and "Date" are as of actual issue.

The issuing laboratory person will secure this form to the blood bag by string, rubberband, or tie knotted to the tag and the blood container before issuing the blood.

"Post-Transfusion Data" – Completed by transfusionist.

"Amount Given _____ ml" – Visual approximation.

"Reaction Description" – Circle appropriate reaction or describe "other" on separate sheet and attach to SF 518.

"Other Difficulties" – Circle item or describe on separate sheet and attach to SF 518.