Ward/Section: ICW1	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b(6)-4	DATE: 7 NOV	TIME: 1630	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 10^6	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			

			CSF			Blood Bank	
Spun Hematocrit		42-52% (M) 37-47% (F)					
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:	DATE:	LAB ID NO.:

Hep A, B, C, + HIV

Ward/Section: ICW I

QUESTING PHYSICIAN: [redacted] b(6)-2

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

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

DATE 17NOV | TIME 1630 | SSN/PSEUDO SSN: [redacted] b(6)-2

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

Liver Panel Plus

======= PICCOLO =======
17/11/03 16:42
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS b(6)-4
DISC LOT #: 3154AA7
OPER #[redacted] DR #: 000
SERIAL #: b(6)-2 0000100494

ALB	2.1*	3.3-5.5	G/DL
ALP	87*	26-84	U/L
ALT	18	10-47	U/L
AMY	67	14-97	U/L
AST	29	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
GGT	8	5-65	U/L
TP	5.6*	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID**

Hep A, B, C
HIV

Complete shipment Form for Hep Panel

- Raw checkpoint in a chicken truck
GSWs to (L)(R) w/ neg

PMHx (-)
PSHx (-)

MEDICAL RECORD - ANESTHESIA

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

NKDA

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

DRUG (Units)															TOTALS	TOTAL EBL
Midazolam (mg)	1														1	<50
Fentanyl (mcg)	50	50	50	50	50			50/125						1	325	
Lidocaine (mg)		60														TOTAL URINE
Propofol (g)		100	100												10	300
Ancef (g)				2	2	2	2									
(g)																
VOLAT AGENT — % del	1.0	0.6	1.1	1.1	2.0	1.2	1.8	1.7								
% e.t.																
AIR L/Min																
N2O L/Min																
O2 L/Min	10	2	2	2	2	2	2	2								

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

FLUIDS SUMMARY
CRYSTALLOID- 500
COLLOID- Ø
BLOOD- Ø

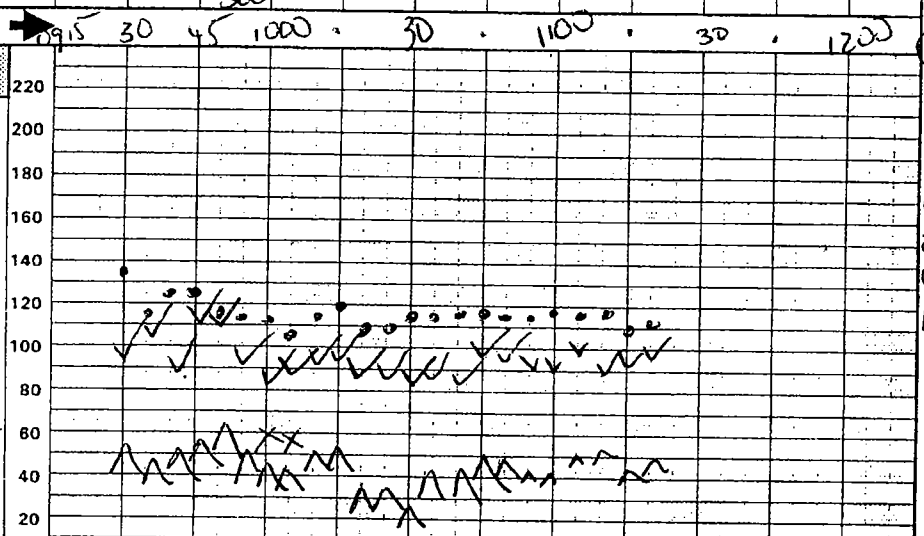
FLUIDS
LINE site (L) Femoral ☐ Warmed → LR (500) 500 #1 — 24/500
Triple Lumen ☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS — MD
URINE - 300

REMARKS
Code drugs with numbers, events with letters
(1) Pre-operative lungs CTA (B) HRR (-) ⊖, NP 14
(2) Room, mont O2 pre-oxygen
(3) UNA removed c̄ pt spontaneously ventilating, to PACU report given.

PHYS STATUS (1) 2 3 4 5 E
BODY WEIGHT: 40 (KG) LB
HEMATOCRIT: 33.8
INITIAL DATA:
BP- 93/52
HR- 134
EQUIP CHECK
OK?- (Y) N
PATIENT RECHECK
OK for PROCEDURE? JR
TIME- 0915

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



VENTIL

VT - ml	+	+	220	230	170	200	190	170
f - breaths/min	+	+	21	21	25	20	23	27
Peak inf pres / PEEP	—	—	—	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	C	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	45	45	41	38	38	42	40	43
BP/oth	FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site available								
	N-M Block (T/4)								
	BIS	+							
Warming blkt	x1 blanket								
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS (1)(2) (3) Position

RECOVERY AT 1120
(PACU) ICU ____ (Specify)
OTHER ____
CONDITION: 98.5
RESP- 14 SpO2- 100%
BP- 91/40 HR- 110

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0915	0925	1127
PROC	Ready	Begin	End
	0935	1000	1110

PROCEDURES and CPT Codes: ATB leads to (R) thigh wound I&D of multiple GSWs to lower extremity

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GLMA

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
LMA #3 placed x1 attempt seated PPV, Suct ETT 2 FB BS

SURGEON: [redacted] b(6)-2

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION: 1
DATE: 13 Nov 2003
PAGE 1 OF 1

MEDCOM - 24043

DA FORM 7389, FEB 1998

MEDICAL RECORD - ANESTHESIA

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

used/wasted

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

DRUG	(Units)													
Prop	(mg)		100											
Fent	(mcg)		100/50	50	50	50	100			200 im	RAW			
	( )													
	( )													
	( )													
	( )													
VOLAT AGENT	Sevo	% del	2.4	2.4	2.4	2.4	2.2	2.0	2.0					
		% e.t.												
AIR		L/Min												
N2O		L/Min												
O2		L/Min	8 2	2	2	2	2	2	2	8				

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

FLUIDS

LINE site												
20ga @ UA	☐ Warmed	1 LR 1000		2 LR 1000								
	☐ Warmed											
	☐ Warmed											
	☐ Warmed											

LOSSES

EST BLOOD LOSS												
URINE -								400				

TOTALS

TOTAL EBL	0 ml
TOTAL URINE	400

FLUIDS - SUMMARY

CRYSTALLOID- 600

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

Pt ID on chart
RAW/Fentan
Induction
Start/Stop
Conversation
S/Vent to
RAW, Report
to RAW Nurse
[redacted]
CRNA

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 40 KG LB

HEMATOCRIT: 21.2

INITIAL DATA:

BP- 104/61

HR- 110

EQUIP CHECK

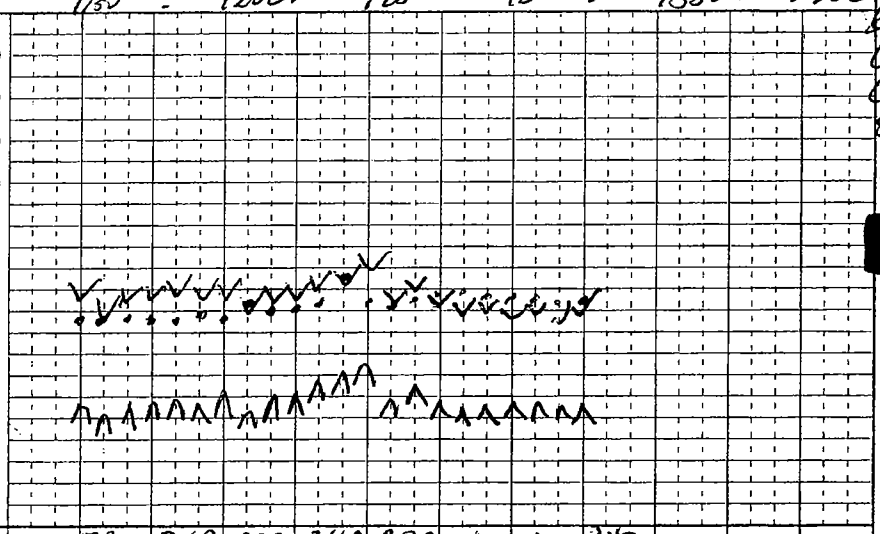
OK?- Y N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME- 11 15

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



VENTIL

	1130	1200	1230	1300	1330	1400	1430	1500
VT - ml	230	280	220	240	270	240	230	340
f - breaths/min	25	20	21	20	10	16	18	17
Peak inf pres / PEEP								
MODE - S(pon), A(ssist), C(on)	SAS	S	S	S	S	S	S	S

MONITORS/ACCESSORIES

		1130	1200	1230	1300	1330	1400	1430	1500
✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	39	39	40	55	40	39	39
BP/oth	✓ FIO2 (Frac or %)	.63	.63	.64	.63	.64	.63	.63	.63
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site Nasal		37.8	37.6	37.1	37.1	36.8	36.8	36.8
✓ AMB	N-M Block (T/4)								
Warming blkt									
Conv warmer									

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

RECOVERY AT 1330

PACU ICU _____ (Specify)

OTHER _____

CONDITION: Pt in NAD

RESP T 96.6 SpO2-96

BP- 130/97 HR- 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1115	1122	1335
	Ready	Begin	End
PROC	1133	1157	1315

PROCEDURES and CPT Codes: I&D PLE

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

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

[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* LMA #3 difficulty

[redacted] b(6)-2

ANESTHESIOLOGISTS: Chris

PROCEDURE LOCATION: 1

DATE: 15 Nov 03

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
Propofol	(mg)	100												
MSO4	(mg)	10	10											
Versed	(mg)	2.5												
	( )													
	( )													
	( )													
VOLAT AGENT	SEVO % del		2.5	2.2	1.5	1.0	1.0	.8						
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	10	3	3	3	3	3	3	8					

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

FLUIDS

LINE site													
20g (L) AC	☐ Warmed	NS		(200)			(250)						
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES

EST BLOOD LOSS													
URINE -	Foley					100							

TOTALS	TOTAL EBL
30	minimal
125	TOTAL URINE
	0

FLUIDS - SUMMARY

CRYSTALLOID- 300

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

1055 Pt in in IC W/ 1, client verified, To O.R. via litter, 1100 Pt on O.R. table, (+) anesthetic, (+) O2, breath, IV induction, Endotracheal, avns < 90, pt padded, 1135 Procedure started

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 40 (KG) LB

HEMATOCRIT: 19/6

INITIAL DATA:

BP- /

HR-

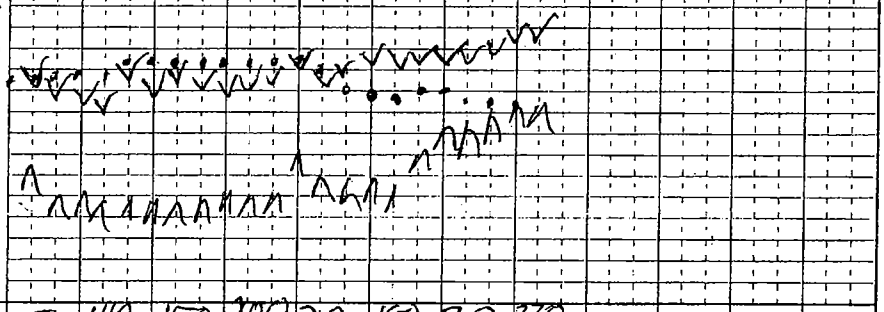
EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE (Y) N

TIME-

TIME 1100 15 30 45 1200 15 30 45 1300

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



VENTIL

VT - ml	—	140	150	200	210	180	200	320
f - breaths/min	20	32	34	24	20	14	13	12
Peak inf pres / PEEP	—	—	—	—	—	—		
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(+)	58	60	58	60	61	68	67
BP/oth	FIO2 (Frac or %)	.55	.54	.54	.58	.58	.58	.60	.59
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	SR	SR	SR
Gas analyzer	TEMP-site	Available							
	N-M Block (T/4)								
Warming blkt									
Conv warmer									

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

RECOVERY AT 1250 → (PACU) ICU ____ (Specify)

OTHER ____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1055	1100	1300
	Ready	Begin	End
PROC	1110	1135	1250

PROCEDURES and CPT Codes: Id (B) + ext.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* Gen

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #3 LMA x 1 attempt s difficulty, soft bite block

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

[redacted] b(6)-4

SURGEONS [redacted] b(6)-2

ANESTHETIST [redacted] CPT CRNA

PROCEDURE LOCATION: OR 1

DATE: 17 Nov 03

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)															TOTALS	TOTAL EBL
Fentanyl/ 50µ/cc			50		50											<10
( )																TOTAL URINE
( )																
( )																
( )																
( )																
VOLAT AGENT	Forane % del		3-2.5-2		1.75		1.5-1								FLUIDS - SUMMARY	
	% e.t.														CRYSTALLOID- 400	
AIR	L/Min														COLLOID-	
N2O	L/Min															
O2 3	L/Min														BLOOD-	
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →																

FLUIDS

LINE site															
	☐ Warmed														
	☐ Warmed														
NS. 500	☐ Warmed								(400)						
	☐ Warmed														

LOSSES: EST BLOOD LOSS; URINE -

REMARKS

Code drugs with numbers, events with letters

(1) U/S taken
(2) Induced c Cidomine 20mg Diprivan 110mg O2, Forane by mask, IV resta.
(3) Procedure begun
(4) Procedure ended
(5) O2, breathing well, TO recovery

PHYS STATUS	TIME →	8:30	45	9:00	15	30	45	10:00	15
1 2 3 4 5 E									
BODY WEIGHT: KG / LB									
HEMATOCRIT:									
INITIAL DATA:									
BP- 121 / 86									
HR- 111									
EQUIP CHECK									
OK?- Y N									
PATIENT RECHECK									
OK for PROCEDURE?									
TIME-									

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

Chart values (220 down to 20): BP by cuff, Heart rate, Resp rate, BR (transduced), TOURNIQUET, ANES, PROC

VENTIL

	8:30	9:00	9:30	10:00	10:30
VT - ml	540	570	480	470	440
f - breaths/min	28	22	16	14	14
Peak inf pres / PEEP	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	AS	AS	AS	AS	AS

MONITORS/ACCESSORIES

		8:30	9:00	9:30	10:00	10:30
✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	31	29	28	30
BP/oth	✓ FIO2 (Frac or %)	64	61	76	81	84
ART line	✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	ST	ST
✓ Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4) (5)

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____

CONDITION: Good

RESP- SpO2- BP- 112/63 HR- 118

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0820	0841	1010
	Ready	Begin	End
PROC	0901	0914	1003

PROCEDURES and CPT Codes: W/O leg wounds & redress

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

b(6)-4

[redacted]

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

Gen Mask

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

#8 mm Airway

S[redacted] b(6)-2

[redacted] RNA

PROCEDURE LOCATION: OR

DATE: 19 Nov 03

PAGE 1 OF

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Fent	(µg)	50/50 50/50/50/50
Lidoprop	(mg)	(40)/50
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT: Iso	% del	2 → → → (7)
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 (3) → → → (8)

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → preop: Gent 250mg IVPB ~ 1°

FLUIDS

LINE site	
(L) FA 20g.	☒ Warmed (1) → → → →
	☐ Warmed
	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: ~40 (KG) LB

HEMATOCRIT:

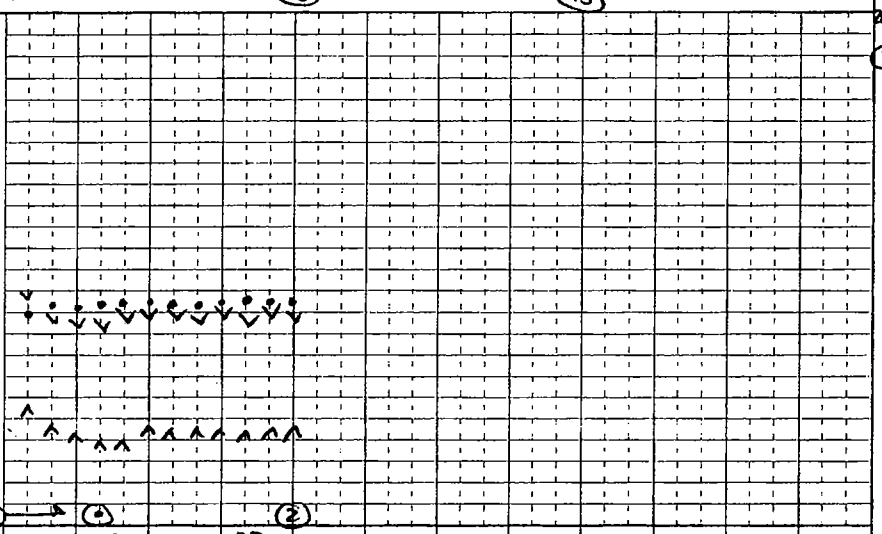
INITIAL DATA: BP- 110 / 67; HR- 99

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1105

TIME (11) • x • (12) • x • (13)

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



VENTIL

VT - ml	–	250	220	270
f - breaths/min	16	18	14	18
Peak inf pres / PEEP	–	–	–	–
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

☒ BP/Auto Cuff	☒ ET CO2 (torr)	–	44	47	47
BP/oth	☒ FIO2 (Frac or %)	82	83	82	80
ART line	☒ SpO2 (%)	100	100	100	100
Steth- PC/ES	☒ ECG	ST	ST	ST	ST
Gas analyzer	☒ TEMP-site BK	–	99	99	98
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → (S), BLE on board < 90° e shoulders, palus ↑

TOTALS	TOTAL EBL
	<20
	TOTAL URINE
	N/M

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

REMARKS

Code drugs with numbers, events with letters

(1) cream/O2/monitors. SIVI, eyes taped, LMA placed A/T → (4) ETCO2 < 5+, B&BS. 20g. PIV placed (L) FA.

(2) LMA removed, O/A placed → PACU, report.

RECOVERY AT 1205

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: stable

RESP- 12 SpO2- 100%

BP- 97/57 HR- 98

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1050	1100	1210
	Ready	Begin	End
PROC	1115	1120	1200

PROCEDURES and CPT Codes: 1+0 BLE

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* Gen LMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #3 LMA

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

[redacted] BLW-4

[redacted]

SURGEONS: [redacted]

ANESTHETISTS: [redacted] BLW-2

PROCEDURE LOCATION: 2

DATE: 21 Nov 07

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
MSO4	(mg)	10												
phenergan	(mg)	25												
propofol	(mg)	100												
	( )													
	( )													
	( )													
VOLAT AGENT Sevo	% del	2.0	2.0	2.0	2.0	X								
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	6 —	2 —	2 —	2 —	2								

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

FLUIDS

LINE site													
20g LFA	☐ Warmed	LR			400								
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES — EST BLOOD LOSS / URINE -

TOTALS	TOTAL EBL
10	min
	TOTAL URINE
	—

FLUIDS - SUMMARY

CRYSTALLOID- 700

COLLOID-

BLOOD-

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 60 KG LB

HEMATOCRIT: —

INITIAL DATA:

BP- 113/72

HR- 104

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Y

TIME- 1040

TIME → 11 30 12 30 13

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

(3) Prep beta x 3. 16g single lumen cath placed to depth of 12 cm using Seldinger approach; Ø complications.

REMARKS

Code drugs with numbers, events with letters

(1) To room via litter SOC monitors, pre O2.
(2) Induced & LMA placed.
(3) Lt SC central placed by anesthesia.
(4) LMA removed, to PACU stable.

VENTIL

VT - ml	200	200	200	200	220
f - breaths/min	26	26	26	26	26
Peak inf pres / PEEP	—	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	39	38	38	33	34
BP/oth	FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	ST	SR	SR	SR	SR
Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT PACU ICU _____ (Specify) OTHER _____

CONDITION: RESP- 26 SpO2- 100 BP- 132/82 HR- 124

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1040	1045	1155
	Ready	Begin	End
PROC	1050	1120	1145

PROCEDURES and CPT Codes:
I&D RLE, Central line

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GLMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Eyes taped, #4 LMA inserted 5 diff. ⊕ ETCO2, BSEB.

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] 13yo ♂ SI
NKDA b(4)-4

SURGEONS: [redacted] b(4)-2
[redacted] CRNA

PROCEDURE LOCATION: 2-2
DATE: 11/23/03
PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
Sufentanyl	(µg)	50/100	50/50											
~~[illegible]~~/propofol	(mg)	100												
	( )													
	( )													
	( )													
	( )													
VOLAT AGENT	Leo % del	15 →	→	→	(X)									
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	10 (3) →	→	→	(X)									

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

FLUIDS

LINE site														
(L) SC D/L	☐ Warmed	(1) →	→	→	→									
	☐ Warmed													
	☐ Warmed													

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	<5
	TOTAL URINE
	N/A

FLUIDS - SUMMARY

CRYSTALLOID- 450

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) Drsm/o2/monitors. SIVI, eyes taped, LMA inserted AH → (+) ETCO2 5+, BBS.

(2) LMA removed, O/A placed → PACU, report.

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: ~40 KG LB

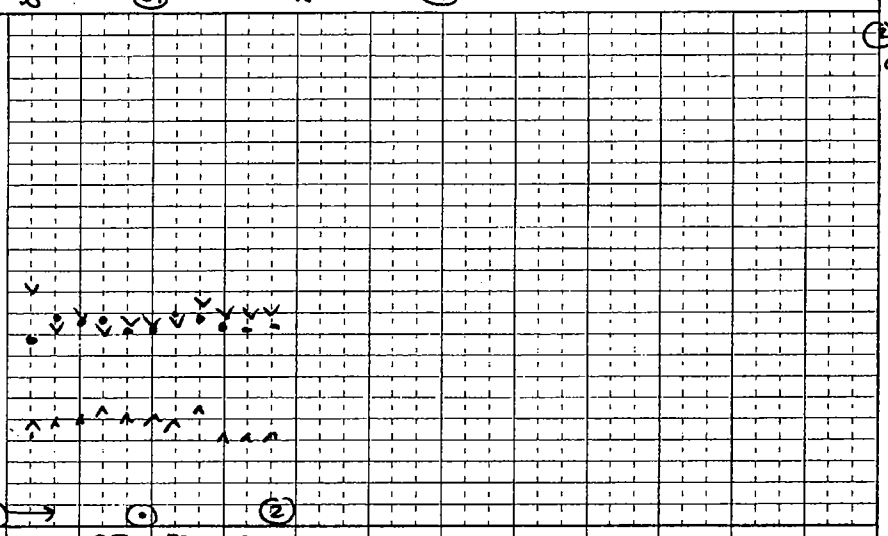
HEMATOCRIT:

INITIAL DATA: BP- 110 / 63 HR- 84

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y TIME- 0832

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



VENTIL

VT - ml	-	250	250	200
f - breaths/min	14	18	12	16
Peak inf pres / PEEP	-	-	-	-
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	-	45	50	51
BP/oth	FIO2 (Frac or %)	59	56	55	55
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site Skin	-	96	96	96
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → (3), BLE on boards <90° e shoulders, poling ↑

RECOVERY AT 0930

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: stable

RESP- 12 SpO2- 100%

BP- 96/57 HR- 92

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0820	0826	0932
	Ready	Begin	End
PROC	0835	0858	0925

PROCEDURES and CPT Codes: I+D Femur

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

Gen LMA

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

#3 LMA - AH

SURGEONS: [redacted]

ANESTHETISTS: [redacted] b(6)-2

PROCEDURE LOCATION: 2

DATE: 25 Nov 03

PAGE 1 OF 1

1134/0 Chest Reconstruct GA.
NKA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													TOTALS
MSO4	(mg)	6												6
Lido/Propofol mix	( )	70/100												
	( )													
Fent	(cc)	1	1		.4									2.4
Phenergan	(mg)		25											
	( )													
VOLAT AGENT: Fon	% del	X2 —	1.5 —	1.5 —	X									
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	6 —	2 —	2 —	8									

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

TOTAL EBL: min

TOTAL URINE: Ø

FLUIDS - SUMMARY
CRYSTALLOID- LR 500
COLLOID- Ø
BLOOD- Ø

FLUIDS

LINE site													
L Sc	☐ Warmed	LR —	200 —	400 —									
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES: EST BLOOD LOSS; URINE -

REMARKS
Code drugs with numbers, events with letters
Prep, SC (B) pt moved self to gurney, to OR
O2 monitors
Stable IV Infusion
SV disp on LMA out

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

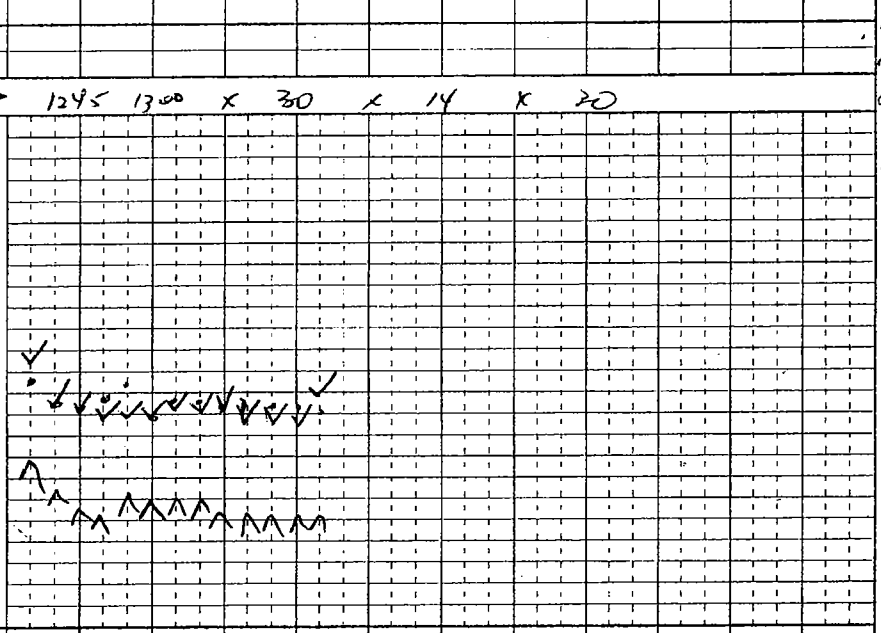
INITIAL DATA:
BP- 123 179
HR- 118

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE: Ly
TIME- 1230

TIME → 1245 1300 x 30 x 14 x 20

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



VENTIL

VT - ml			
f - breaths/min	30	24	18
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	S	S	S

MONITORS/ACCESSORIES

X	BP/Auto Cuff	X	ET CO2 (torr)	44	44
	BP/oth	X	FIO2 (Frac or %)	.6	.6	.6
	ART line	X	SpO2 (%)	100	100	100
	Steth- PC/ES	X	ECG	ST	ST	SR
	Gas analyzer		TEMP-site	AVAIL		
			N-M Block (T/4)			
	Warming blkt					
	Conv warmer					

Mark with letters & symbols, explain under REMARKS

EVENTS / Position → OK — Arms <90°, Head Neck Neutral

RECOVERY AT 1340
(PACU) ICU _____ (Specify)
OTHER _____
CONDITION:
RESP- 16 SpO2- 100% RA
BP- 98/62 HR- 85

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1230	1235	1395
	Ready	**Begin**	**End**
PROC	1245	1255	1330

PROCEDURES and CPT Codes:
ORLy Washout

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GA #4 LMA proseed ē rose BS = B + ETCO2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
SV eyes taped (R eye scab avoidance)

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
#[redacted] b(4)-4
W+1 Bd 3A
Bed 3A

SURGEONS: [redacted] b(4)-2
[redacted] LTC CRNA

PROCEDURE LOCATION: OR
DATE: 11/13/03
PAGE 1 OF

MEDICAL RECORD - ANESTHESIA

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

voided pre-op NKDA

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

DRUG (Units)														TOTALS
Midazolam (mg)	1													1
Fentanyl (mg)	25 –		<25>											250
Lidocaine (mg)	40													140
STP (g)	200													200
UCB (g)	5					1								6
MSO4 (mg)					5			2						7
VOLAT AGENT: Sevo % del		2.0	1.5	1.5	2.0	1.5	1.5	1.5	2.0	1.5	1.5	X		
% e.t.														
AIR L/Min														
N2O L/Min														
O2 L/Min	10	2	2	2	2	2	2	2	2	2	2			

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

FLUIDS

LINE site													
(L) SC CW ☐ Warmed	LR (1000)												
☐ Warmed													
☐ Warmed													
☐ Warmed													

LOSSES: EST BLOOD LOSS; URINE -

TOTAL EBL: 250

TOTAL URINE: 200

FLUIDS - SUMMARY
CRYSTALLOID- 400
COLLOID- Ø
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
(1) Pre-op assessment, pre evaluation, read Inf IV, moved all to table
(2) Rec, monitors, O2, induced, eyelid taped, tube placed, ETT confirmed
(3) ophth gtts OU
(4) Prone, gentle eyes, nose checked
(5) Reflux Sy In
(6) Turned Supine
(7) Reversed, neostigmine 2.5 mg + Glycopyrrolate 0.4; TV > 4 ml/kg; RR > 8 & < 30; Extubated. Complications.
(8) 8A 80mm + NPtube, 1 more 26FR
(9) To PACU; Report to RN; OA removed by

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP- 115/77; HR- 115

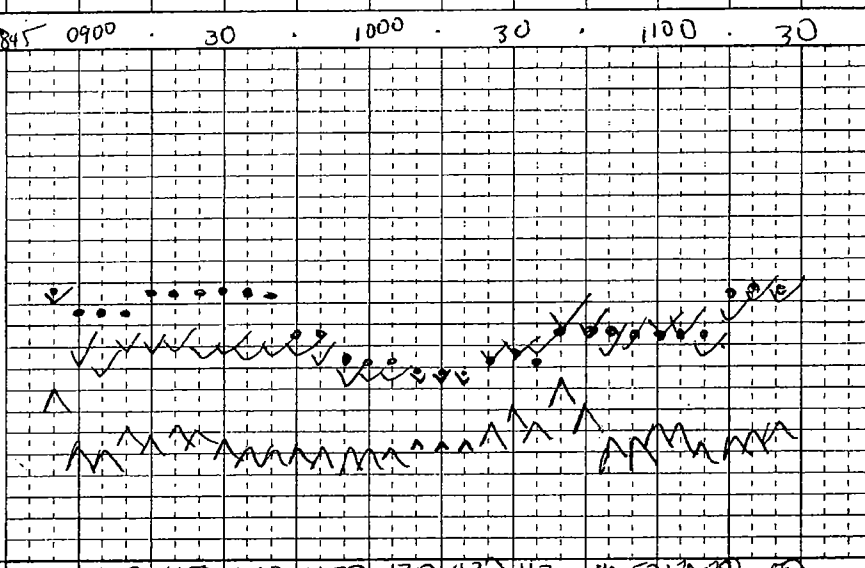
EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? JR

TIME- 0845

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



VENTIL

VT - ml	+	460	450	450	470	420	430	430	40-50	20-200	250
f - breaths/min	+	8	8	8	8	7	6	6	20	21	25
Peak inf pres / PEEP	—	16	16	16	17	17	15	15	—	—	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	S/A	S/A	S

MONITORS/ACCESSORIES

BP/Auto Cuff — ET CO2 (torr)	+	42	38	35	35	34	34	36	53	56	56
BP/oth — FIO2 (Frac or %)	0.47	0.47	0.47	0.47	0.47	0.47	0.55	0.58	0.64	0.66	0.66
ART line — SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer — TEMP-site Skin					34.6	35.1	34.7	34.5	34.3	off	
N-M Block (T/4)		0/4		0/4	4/4	4/4	2/4	2/4	2/4		4/4
BS	+			+							Suct Tet >5sec
Warming blkt — X heat lamp				on	→	→	→	→	→	→	
Conv warmer											

Mark with letters & symbols, explain under REMARKS — EVENTS Position: (1) (2) (3) (4) (5) (6) (7) (8)

RECOVERY AT 1125

PACU (ICU) (Specify)

OTHER I-95A X

CONDITION: stable; alert

RESP- 24 SpO2- 96

BP- 139/82 HR- 139

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0840	0850	1135
	Ready	Begin	End
PROC	0900	0950	1110

PROCEDURES and CPT Codes:
10FR feeding tube / OD EUA / STSG to (B) Cage In DGSWS

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
#[redacted]

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DLx1 MAC 3 Grade 1 view 7.0 ETT 21 cm @ teeth + BBS Suct ETCO2

SURGEONS: [redacted] b/(6)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION: 2(2)

DATE: 2/12/03

PAGE 1 OF 1

NKDA (From previous)

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	0930	0945	0900	TOTALS
FENTANYL	(50)	.50	.50	.25	100
Propofol	(150)				150
Succ	(60)				60
	( )				
	( )				
	( )				
VOLAT AGENT SEVO	% del				
	% e.t.				
AIR	L/Min				
N2O	L/Min				
O2	L/Min	4 L	2	1.5	

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

TOTAL EBL: Min

TOTAL URINE: Ø

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site		0930	0945	0900
L Subclavian ☒	Warmed	100	—	150
D5W 250 (0.1) (250mg Propofol)	☐ Warmed	100	200	250
	☐ Warmed			
	☐ Warmed			

LOSSES

	0930	0945	0900
EST BLOOD LOSS	Ø	Ø	Ø
URINE -	Ø	Ø	Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 45 KG / LB

HEMATOCRIT:

INITIAL DATA: BP-115/75

HR- VR 120-105

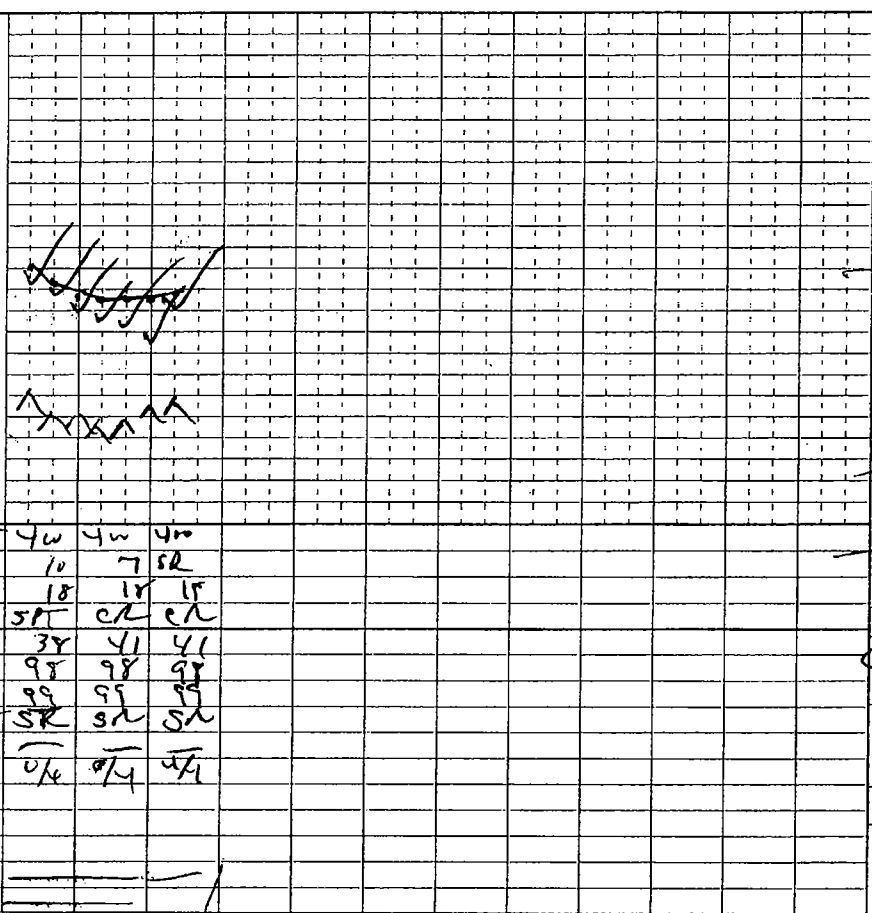
EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? OK

TIME- 0814am

TIME →

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



VENTIL

	0930	0945	0900
VT - ml SPT	400	400	400
f - breaths/min	10	7	5R
Peak inf pres / PEEP	18	18	18
MODE - S(pon), A(ssist), C(on)	SPT	CR	CR

MONITORS/ACCESSORIES

		0930	0945	0900
BP/Auto Cuff	ET CO2 (torr)	38	41	41
BP/oth	FIO2 (Frac or %)	98	98	98
ART line	SpO2 (%)	99	99	99
Steth- PC/ES	ECG ST	SR	SR	SR
Gas analyzer	TEMP-site	—	—	—
	N-M Block (T/4)	0/4	0/4	0/4
Warming blkt	N/A	—	—	—
Conv warmer	N/A	—	—	—

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

REMARKS

Code drugs with numbers, events with letters

Surgical Theatre
2. Supine
Loss in pelvis
Exercise II
Ion, Apath
Rt. Mar. Colic.
Nucleus.
Rt Sciatic
6.0mm ETT
DVI [illegible]
[illegible]
Cisca.

Pharyngeal [illegible]
Breath spont
Sucked ext.
14% O2 mask
To RR VSS
AAOX3

RECOVERY AT

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 16 SpO2- 100%

BP- 120/80 HR- 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0836	0835	0932
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: I+D (RT) Lymphadenitis (2x Fix in place)

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA + ETT

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #6 ETT b(6)-2

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

Major, Anne [redacted] b(6)-4

[redacted]

PROCEDURE LOCATION:

DATE: 6 Dec 03

PAGE OF

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)																		
Versed	(mg)	(1)																	
Fentanyl	(mcg)	(50)			(25)				(25)	(50)									
Propofol	(mg)		150																
	( )																		
	( )																		
	( )																		
VOLAT AGENT	Sevo % del		2.5		2.5		2.5		2.5	1.5 X									
	% e.t.																		
AIR	L/Min																		
N2O	L/Min																		
(O2)	2 L/Min		2	2	2	2	2	8/											

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

FLUIDS

LINE site																		
LR lactate	☐ Warmed	>	>	>	>	>	>	>	/									
Cipro 500cc	☐ Warmed	>	>	>	>	>	>	X										
	☐ Warmed																	
	☐ Warmed																	

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

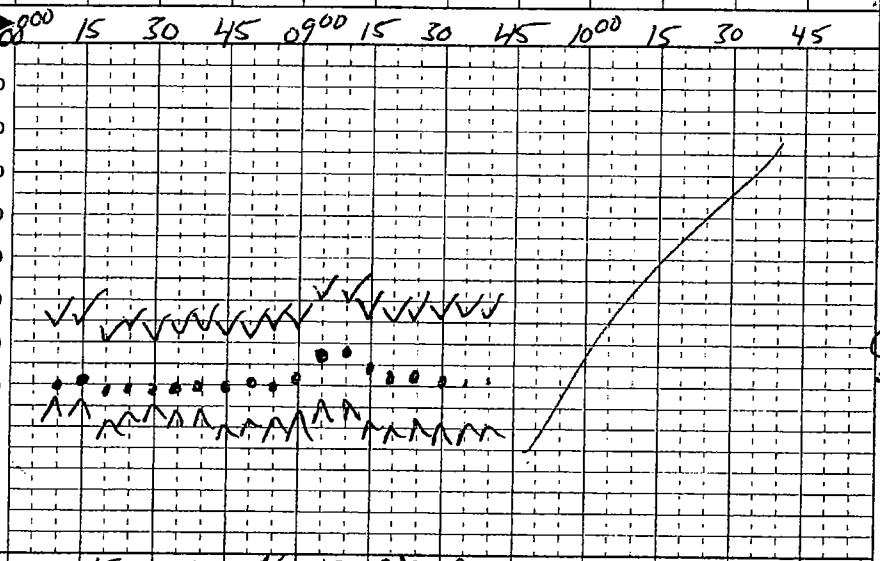
HEMATOCRIT:

INITIAL DATA: BP- 122/77 / ; HR- 82

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 0800

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



VENTIL

VT - ml	150	150	160	130	110	200	
f - breaths/min	25	26	28	27	30	21	
Peak inf pres / PEEP	—	—	—	—	—	—	
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	S	

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	40	41	46	39	38	37	35
BP/oth	FIO2 (Frac or %)	.100	.96	.107	.88	.88	.09	.10
ART line	✓ SpO2 (%)	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR	SR
✓ Gas analyzer	TEMP-site							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2)

TOTALS	TOTAL EBL
1mg	∅
150mcg	TOTAL URINE
150mg	NM

FLUIDS - SUMMARY: CRYSTALLOID- 600cc; COLLOID- ∅; BLOOD- ∅

REMARKS

Code drugs with numbers, events with letters

(1) PT to OR #2-1. Fully monitored on stretcher. Pre O2 via mask. Smooth IV induction. grade I view OP cord via DL c mac 3, 6.0 cuffed ETT. Atraumatic ⊕ETT. BBS clear x4. Eye cone done. All pressure points checked and pad. TX to OR table LLD. Pressure pts rev'd + pad x4

(2) SurX / EKG gel airway, nasal can O2 @ 3L. To pacu VSS. awake and alert

RECOVERY AT: (PACU) ICU _____ (Specify)

OTHER

CONDITION: WNL

RESP- 16 SpO2- 100 BP- 110/68 HR- 88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0810	0943
PROC	Ready	Begin	End
	0816		0943

PROCEDURES and CPT Codes: #7

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETTA

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — 6.0 cuffed ETT. grade I view c mac 3.

SURGEONS: Dr. [redacted] b(6)-2

ANESTHETIST: [redacted] CRNA

PROCEDURE LOCATION: OR 2-1

DATE: 16 Dec 03

PAGE 1 OF 1

ANESTHESIA PLAN OF CARE / PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 13 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 100 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: ____
SURGICAL SERVICE: ____
NPO SINCE: ____

HABITS:
TOBACCO: ____
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

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

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

LABORATORY STUDIES:

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

15 Nov –
Jan

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

GSW to (R) thigh

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Numerous I+D's of GSW's since admission

PHYSICAL EXAMINATION
BP 115/77 HR 115 R – T 35.6 100%
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck Ø FROM
Oropharnyx MPT
Nares ____
CHEST: CTA (B)
CARDIAC: HRR (-) M
EXTREMITIES: ____
IV Access: (L) SC CVL
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

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

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

b(6)-2

The pa[redacted]and and agrees. Questions answered.
Signed [redacted] CRNA Date: 2 Dec 03 Time: 0935 Hrs

PO[redacted]THESIA EVALUATION AND [redacted] (NON ASU)
{ } [redacted]PARENT 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 be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 12 NOV 03 TIME OF ORDER: 0745 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ABOUT TO ICW
2. DX - OPEN (2) FEMUR AND TIBIA FRS
3. CONTINUE STRICT
4. VS - ROUTINE
5. BLOOD ABOT
6. REGULAR DIET

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER

7. IV - LR AT 100 CC/HR. HOSP LOCK WHEN TOLERATE P.O. WELL
8. TYLENOL 650MG P.O. Q 4 HRS PRN
9. PERCOCET TABS, 1 PO Q 4-6 HRS PRN
10. MSO4 2-4MG IVP Q 2 HRS PRN
11. NPO AFTER MIDNIGHT FOR OR IN AM
12. ANCEF 1 GRAM IVPB Q 8 HRS
13. GENTAMICIN 250MG IVPB Q 12 HRS

Noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2

12 NOV 0950

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER

14. FOLEY TO GRAVITY.
15. CBC IN AM.

[redacted]

b(6)-2

240/0500 12 NOV 03

24°V 0040 14 NOV [redacted] 2L AM

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	13NOV03 1020 POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.	1020 13NOV03 [redacted]	
2	Supplemental oxygen. PRN SaO2 < 95%	1020 13NOV03 [redacted]	
3	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a max dose of 10 mg.	1020 13NOV03 [redacted]	
4	Zofran 4 mg IV prn N/V q 15 min, ~~may repeat x ____~~. JM	1020 13NOV03 [redacted]	
5	Metoclopramide 10 mg IV prn N/V x 1.	1020 13NOV03 [redacted]	
~~6~~	Droperidol ____ mg IV prn N/V x 1.	[redacted]	
7	Phenergan 12.5 mg IV prn N/V x 1.	1020 13NOV03 [redacted]	b(6)-2
~~8~~	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.	1020 13NOV03 [redacted]	
9	IVF: LR @ TKO cc/hr.	13 NOV 03 [redacted]	
10	Discharge from recovery status when PACU discharge criteria met.	[redacted]	
11	Demerol 12.5mg - 25mg IV x 1 prn shivering [redacted]	[redacted]	
	[redacted] (CRNA/MAJ) [redacted]	1155 11/13/03 [redacted]	
	b(6)-2		

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

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

DATE OF ORDER 13 NOV 03 TIME OF ORDER 1120 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular Diet
3. NS 2L @ 100cc/hr. HOL LOC2 WW TOLERS PO. WRR.
4. Ophthalmology consult - (R) eye abrasion

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

5. NPO after midnight 14 NOV for surgery 15 NOV 03,
6. CBC Lyte AIM

[redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NOTED 13 NOV 03 @ 1440 [redacted] 2LT, AN

b(6)-2

DATE OF ORDER TIME OF ORDER HOURS

tobradex 1 gtts OD qid, [redacted] b(6)-2

[redacted] 6mo UC

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NOTED [redacted] @ 1250 2LT, AN

b(6)-2

DATE OF ORDER 14 NOV 03 TIME OF ORDER 1230 HOURS

Tincrease tobradex to q20 while awake

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACE [illegible] I MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 15 NOV 03 TIME OF ORDER 1332 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Resume previous order
(2) Regular diet
(3) Rep Hct & Hb when taking P.O. well
(4) NPO after midnight 16 NOV for OR 17 NOV 03
(5) CBC in am

Noted [redacted] 14NOV03 AW

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(6) OOB to ordin TID HOURS

b(6)-2 [redacted]

16NOV03 1800
V.O. - Dr. [redacted] / LT [redacted] b(4)-2
Dulcolax suppository x1 ~~ASY~~

b(6)-2 [redacted]

b(6)-2 noted [redacted] 16NOV 1800

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 17 NOV 03 TIME OF O[redacted] 1240 HOURS

(1) Resume previous orders
(2) D/C foley
(3) Regular diet
(4) NPO after midnight 18 NOV for OR 19 NOV
(5) Colace 100 mg PO BID

Noted [redacted] 17NOV03 AW

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

(6) Wet to dry dressing changes both shoulder/axillae areas BID beginning in AM

b(6)-2 [redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]	17 NOV 03	1530 HOURS	
Noted 17 Nov [redacted]	① HIV, HEP A, B, C, LFTS, PER NEEDLE STICK PROTOCOL		
NURSING UNIT / ROOM NO. [redacted] b(6)-2	[redacted]		[redacted] b(6)-2
PATIENT IDENTIFICATION b(6)-4 [redacted]	DATE OF ORDER 17 NOV 03	TIME OF ORDER 2000 HOURS	
Noted [redacted]	① In & out cath x 1. If void > 400cc, leave foley in. V.O. DR [redacted]		
NURSING UNIT / ROOM NO. / BED NO. 2E 016D 18 NOV 03	[redacted]		b(6)-2
PATIENT IDENTIFICATION b(6)-4 [redacted]	DATE OF ORDER 19 NOV 03	TIME OF ORDER 1000 HOURS	
	① D/C FOLEY ② WET TO DRY DRESSING CHANGES ALL WOUNDS BID ③ REGULAR DIET ④ RESUME PREVIOUS ORDERS ⑤ NPO after midnight 20 NOV FOR		
NURSING UNIT / ROOM NO. / BED NO. b(6)-2 [redacted] Unused WA 19 NOV 03 1100			
PATIENT IDEN [redacted] b(6)-4	DATE OF ORDER OR 21 NOV 03	TIME OF ORDER HOURS	b(6)-2
24/0400	20 OCT 03		[redacted]
NURSING UNIT / ROOM NO. / BED NO.			

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

[redacted] b(

b(6)-2

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: ICW | ROOM NO. | BED NO.

DATE OF ORDER: 21 Nov 03 | TIME OF ORDER: 1250 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Resume previous orders
(2) Regular diet
(3) IVD 2L at 100 cc/hr. 2 Rep
clock when taking PO fluids
(4) NPO after midnight for OR
23 Nov 03

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

(5) not to stay during [redacted]

b(6)-2

NURSING UNIT: 24° | ROOM NO.: 22 Nov 03 0445 | BED NO.: [redacted]

PATIENT IDENTIFICATION

b(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT | ROOM NO. [redacted] | BED NO.

DATE OF ORDER 23 NOV 03 TIME OF ORDER 1150 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Resume previous orders
(2) Regular diet
(3) CXR in PACU to check central line placement
(4) Heparin lock when taking P.O. well. [redacted]

Noted [redacted]

24 23 NOV 03 1350

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF [redacted]

27 NOV 03 @ 1605

(1) NPO ā MN FOR SX, 28 NOV 03.

V.O. DR. [redacted] 2CT, AN

NOTED 11/27/03 @ 1615 [redacted] AN

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2 (A11)

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - 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)-2

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

LIST TIME ORDER NOTED AND SIGN

1. Resume preoperative orders
2. Regular diet
3. Heparin lock IV when taking PO well
4. D/C Glucotrol and Acetaminophen
5. Ciprofloxacin 250 mg IVPB BID
6. Imipenem 500 mg IVPB Q 8 hrs
7. Heel cushions for heel ulcers
8. BID wet to dry dressing changes
9. NPO after midnight 27 NOV 03 for surgery 28 NOV 03 [redacted]

NURSING UNIT: 2B ROOM NO.: 2B BED NO.: [redacted]

Noted 25 NOV 03

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

DATE OF ORDER: 28 NOV 03 TIME OF ORDER: 1325 HOURS

1. Resume preoperative orders
2. Regular diet
3. Heparin lock IV when taking PO well
4. Continue dressing changes
5. OK to shower TID [redacted]

NURSING UNIT: 2B ROOM NO.: 2B BED NO.: [redacted]

Noted 28 NOV 03 1445

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

DATE OF ORDER: TIME OF ORDER:

6. AP & LAT (R) Femur X-ray [redacted]
7. AP & LAT (R) TIB-FIB X-ray [redacted]

b(6)-2 [redacted]

NURSING UNIT: ICW 24 ROOM NO.: 29 NOV 03 0300 BED NO.: [redacted] b(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]			↓	17 Mar 03	1635 HOURS	
			1	NPO after midnight for OR 2 Mar 03 b(6)-2 [redacted]		
NURSING UNIT	ROOM NO. [redacted]	BED NO.				
				~~2400/0200 2 Dec 03~~ [redacted]		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 2 DEC 03 TIME OF ORDER: 1100 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. KUB x'ray to check feeding tube placement.
4. Do not use feeding tube until position confirmed.

PATIENT IDENTIFICATION

b(6)-2 Noted

[redacted]

02 DEC 03 1525

NURSING UNIT | ROOM NO. | BED NO.

KW1 24 | 03 Dec 03 @ 055[redacted]

b(6)-2

DATE OF ORDER | TIME OF ORDER

5. BID wet to dry dressing changes to all (R) lower extremity wounds. Do not remove (L) leg dressing changes.
6. Keep flush IV when taking P.O. well.
7. tube feeds per dietary.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

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

MEDICAL RECORD - DOCTOR'S ORD

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
2/12/03 1130	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN SaO_2 < 95%		
3	Morphine / Meperidine ~~1 mg IV now~~ and 1 mg q ~~3-5~~ 5-10 min prn pain for a max dose of 5 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, ~~may repeat x ____~~		
5	Metoclopramide 5 mg IV prn N/V x 1.		
~~6~~	~~Droperidol ____ mg IV prn N/V x 1.~~		
7	Phenergan ____ mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ TKO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA/MAJ		
	b(6)-2		

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

b(6)-2 AN
unless noted dif

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: C b(6)-4 [redacted]

Noted 6DEC03 1042 [redacted]

DATE OF ORDER: 6 DEC 03 TIME OF ORDER: 0915 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Keep lock IV.
3. Regular diet
4. Leave (L) thigh wound open to air. Do not change (L) calf wound.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER | TIME OF ORDER [redacted] HOURS

[redacted]

6 DEC 03 [illegible]

24 chart ✓ [redacted] OUT/AN 7 Dec 03 0030

NURSING UNIT | ROOM NO. | BED NO.

Noted 9Dec03 2130 [redacted]

09DEC03 1900

- NPO ~~p~~ MN

PATIENT IDENTIFICATION

24° ✓ [redacted]

DATE OF ORDER | TIME OF [redacted] HOURS

~~2LT/AN~~ 10 Dec 0015

10DEC03 0945

- Resume preop meds, activities & diet.
- Pinsite care TID. Use Betadine/Saline mix. leave open to air. Record care in chart per episode

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

- BID wet to dry dressing Δ's (R) thigh, (R) ankle.
- QD Dry Dressing Δ left calf.
- Elevate heels off bed, monitor bed decubitus
- Ambulate c̄ crutches, NWB (R) LE
- Record output JP q Shift [illegible]

Noted 10Dec03 1100 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

[illegible] Dec 03 2345 [redacted] AN

MEDCOM - 24066

b(6)-2 All unless noted dif.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 C [redacted]	14 DEC	1736 HOURS	
	① Straight cath NOW V.O. from Dr [redacted] taken by [redacted] LT/AN		
NURSING UNIT: 1CW2 / ROOM NO. / BED NO.	15 Dec 03 0215 [redacted] LT/AN 24° chart ✓		
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Noted 17 DEC 03 0926 [redacted]	12-17-03	0830 HOURS	
	① Transfer to medical city Hospital. ② Include opthomology note summary & transfer summary.		
NURSING UNIT / ROOM NO. / BED NO.	[redacted]		
18 Dec 03 0500 [redacted] LT/AN 24° chart ✓			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
b(6)-4 C [redacted]	12-19-03	0800 HOURS	
Noted 19 Dec 0830	✓ - D/C staples from left leg ✓ - XR AP+LAT ⓡ Femur AP+LAT ⓛ Tibia ✓ Re: F/u Fx.		
NURSING UNIT / ROOM NO. / BE[redacted]	[redacted]		
1CW2	24° ✓ 20 Dec 03 0230 [redacted]		
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.	0940 [redacted]	
2	Supplemental oxygen.	Keep 5L02 >93% [redacted]	
3	Morphine / Meperidine 1-2 mg IV now and 1-3 mg q 3-5 min prn pain for a max dose of 15 mg.	10/03 eq03 [redacted] 0940 [redacted]	
4	Zofran 4 mg IV prn N/V q 15 min, may repeat x ____.	0940 [redacted]	
5	Metoclopramide 10 mg IV prn N/V x 1.	0940 [redacted]	
6	Droperidol ____ mg IV prn N/V x 1.	0940 [redacted]	
7	Phenergan 12.5 mg IV prn N/V x 1.	0940 [redacted]	
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.	0940 [redacted]	0940
9	IVF: KVO @ ____ cc/hr.	0940 [redacted]	[redacted]
10	Discharge from recovery status when PACU discharge criteria met.	0940 [redacted]	
	b(6)-2		

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

Diagnosis: _____

Height: _____ Weight: 50X9 Diet: _____

Allergies: MCOA

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

MEDICAL RECORD - DOCTOR'S OR[illegible]

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

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21	22	23	24
12 Nov	[redacted]	VS: Routine	08	[redacted]												
			12													
			16													
12	[redacted]	Bedrest	08													
			12													
			16													
12/19/03	[redacted]	Regular diet	08													
			12													
			16													
12	[redacted]	~~NPO p mns~~ Foley	08													
			12													
		to gravity	16													
12 Nov 03	[redacted]	OOB to chair TID	08													
			16													
			24													
17 Nov 03	[redacted]	Wet to dry dressing	10													
		changes both heels/all wounds	22													
		Achilles area BID														
		beginning in AM 11/18														

DIC

12 Nov 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) FEMUR AND TIBIA FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b (6)-2 A71

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12 NOV	[redacted]	Admit to ICW1, Condition - stable	12 NOV03	—	—	[redacted]
12	[redacted]	NPO p MN for OR in am	13 NOV03	0001	—	[redacted]
12	[redacted]	CBC in am	13	0500	—	[redacted]
13	[redacted]	CBC IN AM	14	0400		
13	[redacted]	NPO p MN 14 NOV FOR SURGERY 15NOV03	14	2400		
13	[redacted]	OPTHAMOLOGY CONSULT - (R) EYE ABRASION	14	—	DONE	[redacted]
15 NOV	[redacted]	Resume previous orders	15 NOV	—	—	[redacted]
15	[redacted]	NPO p MN 16NOV03 for OR 17NOV03	17 NOV	0001	—	[redacted]
15	[redacted]	CBC in am	16 NOV	0500	0515	[redacted]
17	[redacted]	Resume previous orders	17 NOV	—	—	[redacted]
17	[redacted]	D/C Foley	17 NOV	1200	1300	[redacted]
17	[redacted]	NPO after midnight 18NOV for OR 19NOV	18 NOV	2359		
17	[redacted]	HIV, Hep ABC, LFT's per needlestick	17 NOV	—	—	[redacted]
		protocol				
17	[redacted]	1 to cath, if >400cc, leave foley in	2005	17 NOV	—	[redacted]
19 NOV	[redacted]	D/C foley	19			[redacted]
19	[redacted]	Resume previous orders	19	—	—	[redacted]

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

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	DEC 01	02	03	04	05	06	07
12NOV	[redacted]	VS routine	6	[redacted]												
			18													
23NOV	[redacted]	reg diet	6													
			18													
23NOV	[redacted]	OOB TC TID	8													
			16													
			24													
17NOV	[redacted]	WTD drsg Δs BIL	10													
		heels, all wounds	22													
		BID	/													
23NOV	[redacted]	NIO: CL drsg Δ using	10	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	
		sterile technique Q72°	/													
25NOV	[redacted]	Heel cushions for heel	06 18	[redacted]												
		ulcers	06 18													
25NOV	[redacted]	B/D WTD DSG Δ	10													
		(continue)	22													
25NOV	[redacted]	NIO: PIN CARE D/D	10	/	/											
			22	/												
29NOV	[redacted]	RO PTS Amb c crutches	06 18			/										
			18			/										
02DEC03	[redacted]	Tube feeds osmolite	06													
		HN 200cc bolus q4°	10													
		while awake (NO	14													
		0200 feed)	18								[redacted]					
			22													
4DEC03	[redacted]	NIO: BRADEN SCALE	06	/					DONE							
		Q 7 DAYS	18	/					/							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) FEMUR AND TIBIA FX

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 A11

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 NOV	[redacted]	NPO p̄ MN 20 NOV 03 for OR 21 NOV 03	21 NOV	0001	—	[redacted]
21	[redacted]	Resume previous orders	21 NOV	—	—	[redacted]
21	[redacted]	NPO p̄ MN 22 NOV for OR 23 NOV 03	23 NOV	0001	—	[redacted]
23 NOV	[redacted]	Resume previous orders	23	—	—	[redacted]
23	[redacted]	CXR in PACU to check CL placement	23	DONE	—	
24 NOV	[redacted]	Resume Previous orders	25	—	—	[redacted]
25 NOV	[redacted]	NPO p̄ Midnight 27 NOV 03 for	27	2359	—	[redacted]
	----	surgery 28 NOV 03				
27 NOV	[redacted]	NPO p̄ MN FOR SX 28 NOV 03	27	2359	—	[redacted]
28 NOV	[redacted]	Resume previous orders	28	—	—	[redacted]
28	[redacted]	AP/LAT Ⓡ FEMUR X-RAY	28	—	—	[redacted]
28	[redacted]	AP/LAT Ⓡ TIB-FIB X-RAY	28	—	—	[redacted]
01 DEC	[redacted]	NPO p̄ MN for OR 02 DEC 03	02 NOV	0001	—	[redacted]
02 DEC	[redacted]	Resume previous orders	02	—	—	[redacted]
02	[redacted]	KUB x-ray to check FT placement	02	DONE	IN	[redacted]
02	[redacted]	Tube feeds per dietary	02			

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

b(6)-2 AN

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 12 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20										
12 NOV	[redacted]	VS routine	D	[redacted]												
			N													
18 NOV	[redacted]	Reg diet	B	[redacted]												
			L													
			D													
18 NOV	[redacted]	COBTC TID	08	[redacted]												
			16													
			24													
18 NOV	[redacted]	NIO: CL Dsg Δ using Sterile technique q72°	10	/	[redacted]	/	/	/	/	/	/	/	/	/	/	/
27 NOV	[redacted]	NIO: Turn q2°	D	[redacted]												
			N													
6 Dec	[redacted]	Braden scale q7D	10	/	/	[redacted]	/	/	/	/	/	/		/	/	/
10 Dec	[redacted]	Pin site care TID. Use Betadine/saline mix.	06	[redacted]												
			14													
			22													
10 Dec	[redacted]	W&D dsg Δ (R) thigh	08	[redacted]												
		Ankle BID	20													
10 Dec	[redacted]	(L) dsg dry - (L) calf	08	[redacted]												
10 Dec	[redacted]	elevate heels off bed	D	[redacted]												
		Monitor heel & calcub	N													
10 Dec	[redacted]	Ambt crutches, NWB RLE	D	[redacted]												
			N													

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Open (R) femur fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

C[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 All

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 12 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Dec	[redacted]	D/c Staples from (L) leg	19Dec	AM	1000	[redacted]
19Dec	[redacted]	XR AP & LAT (R) femur, (R) tibia (f/u fx)	19Dec	AM	1000	[redacted]

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

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10	11	12	13	14	15	16	17
12NOV	[redacted]	VS Routine	D	[redacted]												
			N													
28NOV	[redacted]	Reg Diet	B													
			L													
			D													
23NOV	[redacted]	OOBTC TID	08													
			16													
			0													
23NOV	[redacted]	N10: CL DSG Δ	10			[redacted]			[redacted]			[redacted]			[redacted]	
		using sterile technique														
		Q7D														
25NOV	[redacted]	Heel cushions for	D	[redacted]												
		Bed ulcers	N													
26NOV	[redacted]	N10: Pin care BID	10			[redacted]										
			22													
28NOV	[redacted]	Amb. c crutches.	D	[redacted]												
			N													
5Dec	[redacted]	Braden scale Q7days	10	[redacted]												
2Dec	[redacted]	BID w ⇒ Dsg Δ's to	10			[redacted]										
		all (R) lower extremity	22													
		wounds. Do not remove														
		(L) leg dsg changes														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) femur fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

C [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verity by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6DEC	[redacted]	Resume previous orders	6DEC	//	done	[redacted]
9Dec	[redacted]	NPO 5 MN	10Dec	0000	done	[redacted]
10Dec	[redacted]	Resume prepopactivities + diet	10Dec	—	1100	[redacted]
14DEC	[redacted]	Straight Cath Non	14DEC	1745	1745	[redacted]
17DEC	[redacted]	Transfer to medical city Hospital	17DEC			
17DEC	[redacted]	Include opthamology note summary in	17DEC			
	----	transfer summary				

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

b(6)-2 AM

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. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28	29	30	1	2	03	4	5
27	[redacted]	NIO: Turn Q2°	02	[redacted]									
			04										
			06										
			08										
			10										
			12										
			14										
			16										
			18										
			20										
			22										
			24										
01 DEC	[redacted]	BID wet to dry dsg c's	10										
		to all @ lower extrem	22										
		wounds											
02	[redacted]	Do not remove @ leg	06										
		dsg changes	18										
			18										
			06										
02	[redacted]	Do not use feeding	06										
		tube until position	18										
		confirmed	06										
02	[redacted]	Tube feed of Osmolite	02										
		HN 200cc bolus q4°	06										
		while awake	10										
			14										
			18										
			22										

D/C 02 DEC 03

NGT D/C'd 4 DEC 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open R femur & tibia fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

MEDCOM - 24078

b(6)-2 All

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 12 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
3 Dec 03	NO [redacted]	Wound CNS consult	3 Dec		1000 [redacted]	
3 Dec 03	NO [redacted]	Physician to look at heel	3 Dec	On Rounds	1000 [redacted]	
3 Dec 03	[redacted]	Nutrition consult	2 Dec	On Chart at 1015	[redacted]	
3 Dec 03	[redacted]	PT consult (PT informed Cheryl)	3 Dec			

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

b(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10	11	12	13	14	15	16	17
27 Nov	[redacted]	N (R): Turn q 2°	02	/	[redacted]				[redacted]							
			04	/												
			06	/												
			08	/												
			10	/												
			12													
			14													
			16													
			18													
			20													
			22	GM												
			24	Em												
6 Dec	[redacted]	Braden scale q 7D	01 21 09	/	[redacted]	/	/	/	/	/	/	/	/	/	/	/
6 DEC	[redacted]	Leave (L) thigh wound	D	/	[redacted]											
		open to air. Do not	N	/												
		change (L) calf wound														
10 Dec	[redacted]	Pin site care TID. Use	06	/					/	[redacted]					[redacted]	
		betadine/saline mix. Record	14	/					[redacted]							
		care in chart per episode.	22	/					[redacted]							
10 Dec	[redacted]	Wet to dry dressing Δ's	08	/					[redacted]							
		(R) thigh (R) ankle BID	20	/					[redacted]							
10 Dec	[redacted]	QD Dsg Δ - dry - to (L) calf	08	/					[redacted]							
10 Dec	[redacted]	Elevate heels off of bed, monitor	D	/					[redacted]							
		heel decubitus	N	/					[redacted]							
10 Dec	[redacted]	Ambulate c̄ crutches	D	/					[redacted]							
		NWB (R) LE	N	/					[redacted]							
10 Dec	[redacted]	Record JP output	D	/					[redacted]						D/C	
		Q shift	N	/					[redacted]						13 Dec 03	

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: open (R) femur / tibia Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

b(6)-4

C [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12	13	14	15	16	17	18	19	20	21	22	23	24
12/23 NOV03	[redacted]	LR @ 100cc/hr HL	06	[redacted]												
	-----	when tol po well	18													
12	[redacted]	Ancef 1 gram IVPB	06													
	-----	q8°	14													
	-----		22													
12	[redacted]	Gentamycin 250mg	10													
	-----	IVPB q12°	22													

13	[redacted]	TOBRADEX ÷ 6TTS OD QID	06	/	/	JP										
	-----		12	/	/	MA										
	-----		18	/	MG											
	-----		24	/	W											

14NOV	-----	↑ INCREASE TOBRADEX TO	02	/	/	/										
	-----	Q 2° WHILE AWAKE (÷ 6TTS)	04	/	/	/										
	-----		06	/	/	/										
	-----		08	/	/	/										
	-----		10	/	/	/										
	-----		12	/	/	/										
	-----		14	/	/											
	-----		16	/	/											
	-----		18	/	/											
	-----		20	/	/											
	-----		22	/	/											
	-----		24	/	/											
17NOV	VM	Colace 100mg PO BID	10	/	/	/	/	/	/	/	/					
	-----		22	/	/	/	/	/								

ORDER Δ'd

D/Ced

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN @ FEMUR AND TIBIA FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 MEDCOM - 24081

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
16NOV	[redacted]	Dulcolax suppository x1	16NOV			[redacted]	
25	[redacted]	Resume previous orders	25				
		b(6)-2 A11					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
12NOV	[redacted]	Tylenol 650mg PO q 4° prn	D/T	12NOV 1430	1200 2200	13NOV 1500	14NOV 0950	14NOV 2000	15NOV 1915	15NOV 2330	16NOV 2015	21NOV 2000	23NOV 1925		
			D/I	650 mg	650	650	650	650	650 mg	650 mg	650 mg	650 mg	650 mg		
12	[redacted]	Percocet tabs 1 po q 4-6° prn	D/T	18NOV 0330	20NOV 0600	20NOV 2330	22NOV 1140	24NOV 2020							
			D/I	tpo	tpo	[redacted]									
12	[redacted]	MSO4 2.4mg IVP q 2° prn	D/T	17NOV 0905	THIS MED	18NOV 0800	18NOV 0815	18NOV 2130	19NOV 2115	20NOV 1130	24NOV 1030	24NOV 1500			
			D/I	4mg	NOT GIVEN	2mg	2mg	2mg	4mg	2mg	4mg	2mg			

*U.S. GPO: 1998-454-110/95216

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10	11	12	13	14	15	16	17	18
25 NOV	[redacted]	IVC IV when tol	[redacted]														
12-10	[redacted]	PO well	[redacted]														
25 NOV	[redacted]	Ciproflaxin 250mg	08	[redacted]													
12-10	[redacted]	IVPB BID	20	[redacted]													
25 NOV	[redacted]	Imipenem 500mg	06	[redacted]													
12-10	[redacted]	IVPB Q8hrs.	14	[redacted]													
			22	[redacted]													
24 NOV	[redacted]	Tobradex to OD	02	[redacted]													
10 Dec	[redacted]	while awake. OD	04	[redacted]													
			06	[redacted]													
			08	[redacted]													
			10	[redacted]													
			12	[redacted]													
			14	[redacted]													
			16	[redacted]													
			18	[redacted]													
			20	[redacted]													
			22	[redacted]													
			24	[redacted]													
17 NOV	[redacted]	Colace 100mg PO	10	[redacted]													
10 Dec	[redacted]	BID	22	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) femur & tibia fx

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

C [redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

b(6)-2 AW

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. 12 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19 20													
25NOV	[redacted]	HL Fv when to feeding	0	[redacted]													
copied 12-18		PO well	N	[redacted]													
25NOV	[redacted]	Ciprofloxin 250mg	08	[redacted]													
copied 12/18	[redacted]	IVPB BID	20	[redacted]													
25NOV	[redacted]	Imipenem 500mg	06	[redacted]													
copied 12/18		IVPB q8°	14	[redacted]													
			22	[redacted]													
29NOV		Tobradex to OD	02	[redacted]													
copied 12/18	[redacted]	q2° WA	04	[redacted]													
			06	[redacted]													
			08	[redacted]													
			10	[redacted]													
			12	[redacted]													
			14	[redacted]													
			16	[redacted]													
			18	[redacted]													
			20	[redacted]													
			22	[redacted]													
			24	[redacted]													
17NOV	[redacted]	Colace 100mg PO	10	[redacted]													
copied 12/18	[redacted]	BID	22	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) open tibia/femur fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

C [redacted]

b(4)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 12 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
12-10	[redacted]	—					
12-10	[redacted]	Resume pre-op meds			noted	[redacted]	
		b(6)-2 All					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
12 NOV	[redacted]	Tylenol 650mg PO Q4° PRN	12 DEC 1215	13 DEC 2000	16 DEC 1904	18 DEC 0745												
			650 PO	650 PO	1 PO	650 PO	[redacted]											
12 NOV	[redacted]	Percocet tabs 1 PO Q4-6° PRN.	12-5 1100	5 DEC 1 PO	5 DEC 1 PO	6 DEC 1 PO	7 DEC 1 PO	7 DEC 1 PO	8 DEC 0630	8 DEC 2100	9 DEC 0800	9 DEC 1900	10 DEC 0245	10 DEC 1300	10 DEC 2015	10 DEC 0155	11 DEC 0830 1 PO	12 DEC 0315 1 PO
				2000	2019	1438	0550	1606	1 PO	1 PO	1 PO	1 PO	1 PO	1 PO	1 PO	[redacted]		
12 NOV	[redacted]	MSO4 2-4mg QD° PRN.	5 DEC 0019 4mg IVPO	10 DEC 2230 4mg IV	7 DEC 0430 4mg	8 DEC 0100 4mg IV	8 DEC 0730 4mg	8 DEC 1800 4mg	11 DEC 0100 4mg IV	12 DEC 1340 0mg	9 DEC 0215 4mg IV	10 DEC 2115 2mg IV	11 DEC 2mg IV					
			[redacted]															
12 Dec (open)	[redacted]	Percocet tabs 1 PO Q4-6° PRN	12 DEC 0030 1 PO	13 DEC 1000 1 PO	13 DEC 1810 1 PO	14 DEC 0120 1 PO	14 DEC 0800 1 PO	15 DEC 0900 1 PO	16 DEC 1030 1 PO	16 DEC 2000 1 PO	17 DEC 0445 1 PO	17 DEC 0830 1 PO	18 DEC 1900 1 PO	18 DEC 2000 1 PO				
			[redacted]															

USAPA V1.00

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. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	01	02	03	04	05	06	07	08
25Nov 02D&C03	[redacted]	H/L IV when tol Po.	06	[redacted]													
	-----	Well	18														
			06														
25NOV	[redacted]	Ciprofloxin 250mg	08	[redacted]													
	-----	IVPB BID	20														
25NOV	[redacted]	Imipenem 500mg IVPB	06	[redacted]													
	-----	Q8hrs.	14														
	-----		22														
27NOV	[redacted]	↑ Tobradex to Q2°	02	[redacted]													
	-----	while awake (1 gtts)	04														
	-----		06														
	-----		08	[redacted]													
	-----		10														
	-----		12														
	-----		14														
	-----		16														
	-----		18														
	-----		20														
	-----		22														
	-----		24														
17NOV	[redacted]	Colace 100mg PO BID	10	[redacted]													
	-----		22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) femur & tibia fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(4)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION OF 1 [illegible] EXHAUSTED.

MEDCOM - 24086

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 12 Yr. 03

Verify by Initialing: Order Date	Clerk/Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
25	[redacted]	Resume previous orders.	25	—	—	[redacted]
		b(6)-2				

Order/Expir Date	Clerk/Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
12NOV	[redacted]	Tylenol 650mg PO q4° prn	D/T	1000													
			D/I	2BS													
12NOV	[redacted]	Percocet tabs 1 PO q4-6° PRN	D/T	25NOV 1600	25NOV 2080	26NOV 0800	26NOV 1130	26NOV 2000	27NOV 0800	27NOV 1115	27NOV 2215	28NOV 2200	29NOV 1205	29NOV 1630	30NOV 0800	30NOV 0930	01DEC 1640
			D/I	[redacted]													
12NOV	[redacted]	MSO4 2-4mg q2° PRN	D/T	25NOV 0930	25NOV 1040	26NOV 0000	30NOV 1030	30NOV 2240	01DEC 0930	01DEC 1210	01DEC 1330	2DEC 3130	3DEC 0900	3DEC 0915			
			D/I	2mg	2mg	4mg	4mg	4mg	4mg	4mg	4mg	4mg	4mg	4mg			
			D/I	[redacted]													
02DEC	[redacted]	Percocet 1 tab PO q4-6° prn	D/T	2DEC 1500	2DEC 2010	3DEC 0430	3DEC 0900	3DEC 1650	3DEC 2300	3DEC 0745	4DEC 0130	4DEC 0730					
			D/I	[redacted]													

*U.S. GPO: 1998-454-110/95216

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): 11

Date: 11/13/03
Time In: 1125
Allergies:
Pre-op V/S: 83 [illegible] 14-134
Procedures: I&D OR MULTIPLE GSW

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP EBL 250 cc
Meds/Times: [illegible] 250 mcg [illegible] 60 [illegible]

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

Pre Op Meds History

Time	1125	1130	1135	1140	1210	1225	1240	1255
SaO2	15[illegible]	20	98	[illegible]	100	[illegible]	100	100
FiO2	RA	NC	NC	RA	NC	NC	NC	RA
Methods	PC	NC	NC	RA	[illegible]	[illegible]	[illegible]	[illegible]
240								
220								
200								
180								
160								
140								
	135	128	131	133				
120		25					120	
					113	109		115
100								
80								
	73	76		74			72	67
60			69		69	69		
40								
20								
HR	117	112	120	130	123	120	135	125
RR	16	15	12	16	12	14	16	16
T	98							

Time										
Pain (0-10)										
LOS										

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1125	RL	800	L FCM	[redacted]	200
1250	RL				

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	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			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	4	5	10

Codes

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

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

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/13/03

[redacted]TION (For typed or written entries give: Name – last, first, m[redacted]: hospital or medical facility)

[redacted] b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1200		Demerol 25 mg.	IVP	8	INC	[redacted]
					b(4) 2	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(B) Left	Limited	+	+	B	C	Pk
15'	(B) Left	Limited	+	+	B	C	Pk.
30'	B Left	Limited	+	+	B	C	Pk.
45'	B Left	Limited	+	+	B	C	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							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm 1125	(B) Left	ACE Bandage	dry
30' 1205	(B) Left	ACE Bandage	dry
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount
1125	Foley	Yellow	—
1250	Foley	Yellow/clear	200

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1125	normal		S, S, (+)

NURSING NOTES

1125 Pt came from OR - BP quiet - has oral airway, changed to nasal ~~cannula~~ trumpet - with nasal cannula @ 4L. Pt in deep sedation. Dressing & left leg intact w/ fix (B) leg. bottom and R foot intact. Pt given 25 mg of Demerol for discomfort.

1140. Pt giving moaning. Uses Mobile support pillow elevation of leg. Pt has corneal abrasion - Dr [redacted] ordered Tobradex eye drops.

1150 Pt alert & oriented both eyes, arousable at verbal command and R foot. [redacted] Reports pain of (2)

Discharge Criteria:
Date: 11/13/03 Time: 12:50 PARS: 10
BP: 117/67 T: 97.2 HR: 129 RR: 17 SaO2: 100%
Pain Level at D/C (0-10):
Intake: NL 200cc Output: Foley 200cc
Additional Data:
Transferred To: PCU 1
Report Given To: RN
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recover[redacted]
Sign[redacted]

2

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: 15 Nov 03
Time In: 1335
Allergies:
Pre-op V/S: 164/61 110
Procedures: [illegible]

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP 400 EBL min
Meds/Times: Fentanyl

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

Pre Op Meds History

Time	1335	1340	1345	1400	1415
SaO2	96	92	98	96	96
FiO2	RA	NC 2L	NC 4L	RA	RA
Methods					
240					
220					
200					
180					
160		✓			
140	✓		✓	✓	✓
120					
100	^	^	^	^	^
80					
60					
40					
20					
RR	12	14	14	14	14
T	97				

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1335	LR	500	[illegible]	DR	500

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	1
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes

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

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

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

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

b(u)-2

[redacted]

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 Nov 03

[redacted] (first, middle; grade; date; hospital or medical facility)

Name – last.

b(u)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	RLE	ROM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

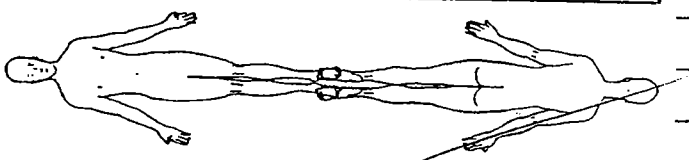
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Bilig	Ext fix c Ace	yes
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1335	SR	-	-

NURSING NOTES

Pt to Recovery Room c/ Dr. OK via Gurney S/P I+D (C) Bilat Extremity Ext fix Pt Ace intact. NV's intact. VS 138/97 P-109 R-16 SpO2 96% - 2L NC will continue to monitor. [redacted]

no (u) - 2 A11

Discharge Criteria:
Date: ~~14 Nov~~ 15 Nov Time: 1475 PARS: 9
BP: 138/93 T 96.2 HR: 105 RR: 18 Sa02: 94
Pain Level at D/C (0-10):
Intake: 700 Output:
Additional Data:
Transferred To:
Report Given To: ICW
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Signatu [redacted]

MEDCOM - 24091

WAMC OP 173-E

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): 11

Date: 11/17/03
Time In: 1300 NA
Allergies: NKA
Pre-op V/S: _____
Procedures: I&D of Bony Ext Fix of (R) Leg.

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

OR Intake: Crystalloid 300 Colloid _____
OR Output: UOP _____ EBL M.N.
Meds/Times: MSO4 10 mg, Propofol 100 mcg, Versed 2.5 mg

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

Pre Op Meds

History

Time	1300	1305	1310	1315	1330	1350	1400
SaO2	98	97	99	99	99	99	100
FiO2		5L	5L	5L	5L	5L	
Methods	OD	FM	FM	FM	FM	FM	FM
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	13	12	15	19	15	19	13
T	98					98.4	

Time	
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1300	NS	600	L Arm	TU	-50

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	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] blue-2 SNF

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/17/03

PATIENT'S IDE[redacted]ped or written entries give: Name – last, first, middle; grade; da[redacted] or medical facility)

☐ 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

NEUROVASCULAR

Time 1300	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) LEG	LIMITED	+	+	B	C	PK
15'	(R) LEG	LIMITED	+	+	B	W	PK
30'	(R) LEG	LIMITED	+	+	B	W	PK
45'	(R) LEG	LIMITED	+	+	B	W	PK
60'							
90'							
D/C							

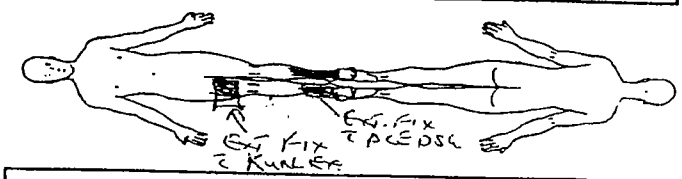
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1300	(R) LEG	KUNLER, ACE	+
30' 1330	(R) LEG	KUNLER, ACE	+
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1300	FOLEY	YELLOW	—
1400	FOLEY	YELLOW	25

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1300	S_2	NO	

NURSING NOTES

1300. Pt admitted from OR. PACU easily arousable, moves arms. Pt has referred pain (R) hip & (R) thigh and (R) calf areas. (R) thigh covered with Kunler, slight elevation with serous fluid at side of dressing over leg. No drainage from (R) calf on ACE bandage. Pt has dressing on (L) ankle. No calf area. ace bandage secured wound site.
1305. Pt not dropped to 71%. FM est OR given to Pt. Pt PO climbed to 100 mg. Pt airway cleared complained of dryness in throat due to endotracheal tube SIC intubation. Pt has bowel sounds and foley in ~~foley~~ intact and patent.
1400. Pt able to go awake and give "thumbs up sign". Also to say "sister". Pt once arose, goes back to sleep. Easily arousable by verbal stimuli.
Pt transferred to ICW [redacted]

b(6)-7

Discharge Criteria:
Date: 11/17/03 Time: 1400 PARS: 10
BP: 133/77 T: 98 HR: 123 RR: 10 Sa02: 100%
Pain Level at D/C (0-10):
Intake: 50 cc Output: 25 cc URINE
Additional Data: —
Transferred To: ICW
Report Given To: LT [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Signature [redacted] 15/Sr

WAMC OP 173-E

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: 19 NOV 03
Time In: 1010
Allergies: NKDA
Pre-op V/S: 121/86 HR 111
Procedures: w/o left wound

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

OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL 10 cc
Meds/Times: Pre-op 100 mcg Fentanyl

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1010	1020	1030	1040	1050
SaO2	95	97	97	97	97
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	10	12	15	12	
T	97			96	

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	Ø	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	1	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	6	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

b(6)-2

[redacted]

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)

	DEPARTMENT/SERVICE/CLINIC	DATE
LT AW	PACU / ICU 3	19 NOV 03

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

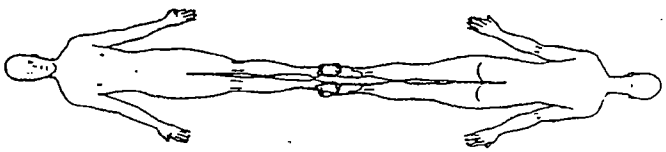
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	RLE	EXFIX	Ø
30'	LLE	ACE	Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Pt arrived via gurney to PACU from OR accompanied by OR staff. Pt sedated reactive to pain stimuli VSS. (P) ORIF ext. fix. (P) wound c̄ dressing CDI pulses +2 bilateral extremities. @ 1020 Pt woke up crying & confused. encourage dip breathing & cough pt tolerated well.

Discharge Criteria:
Date: 19 Nov 03 **Time:** 1050 **PARS:**
BP: 132/91 **T:** 96.6 **HR:** 126 **RR:** 12 **Sa02:** 97%
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: ICU bed-2
Report Given To: SPC [redacted]
Transferred Via: W/C [redacted] urney Ambulance
Transferred By: Lt [redacted]
Cleared IAW Recov [redacted]
Signat [redacted] LEAD

MEDCOM - 24095

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

DTSG APPROVED (Date)

Date: 21 NOV 03
Time In: 1306
Allergies:
Pre-op V/S:
Procedures: exploy @ thy + D mp

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid
OR Output: UOP EBL <20
Meds/Times: 7cc Fent

ICW 1
12-14 yo
ex 4
IV @ fc
He
200 @ fc
NW

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1300	1310	1315	1320	1330	1340	1350	1355	1400	1405
SaO2	100	100	100	98	99	99	98	99	99	99
FiO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Methods										
240										
220										
200										
180							✓	✓	✓	✓
160										
140				✓	✓	✓				
120			✓	•	•	•	•			
100	✓	X •	•		∧	∧		•	•	•
80			∧	∧				∧	∧	∧
60	∧		∧				∧			
40										
20										
RR	11	15	11	16	17	12	13	18	17	16
T	97.7			98			97.1			

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1705	NS	50cc	@fc	IV	—

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0	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	1	1
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	9	9

Codes

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

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

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

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

(Continue on reverse)

PREPARED BY: [redacted] b(6) c

DEPARTMENT/SERVICE/CLINIC: ICU3/PACU

DATE: 21 NOV 03

[redacted] (For typed or written entries give: Name – last, date; hospital or medical facility) EPW

[redacted]

b(6)-4

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

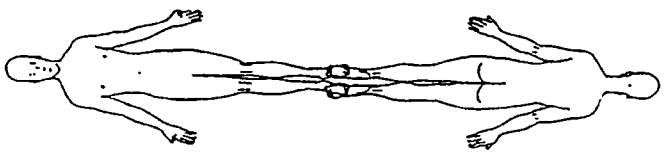
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LLE	–	–	+	B	W	LFK
15'	LLE	–	–	+	B	W	"
30'	LLE	–	–	+	B	W	"
45'							
60'							
90'							
D/C	"	"	"	"	"	"	"

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	(R) hip	gauz	serosang
30'	"	"	"
60'			
D/C	"	"	"



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1815	Sinus Tac	Ø	Ø

WAMC OP 173-E

NURSING NOTES

D/I NOV 03 received pt alert from OR accompanied by [redacted] Pt has infusion to (R) thigh + (R) foot/LE. Drsgs to (R) LE + (R) LE w/ gauze dry c/d/i. (R) hip w/ serosang drainage. Pulse ox to (L) thumb reading 98-100% RA. BP cuff reading incorrect, D/C cuff, results stabilize. CRNA [redacted] aware BP's and unconscious. Meets criteria for D/C [redacted]

Discharge Criteria:
Date: 21 NOV Time: 1405 PARS: 9
BP: 175/95 T: 97.1 HR: 106 RR: 16 Sa02: 99
Pain Level at D/C (0-10):
Intake: 50cc Output: ø
Additional Data:
Transferred To: ICU
Report Given To: [redacted] b(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: LT [redacted]
Cleared IAW Recovery Room SOP [redacted]
Charge Nurse Signatu[redacted]

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

13 y/o

OTSG APPROVED (Date)

Date: 23 NOV 03
Time In: 1205
Allergies: NKDA
Pre-op V/S: 113/72 164
Procedures: IVD ELE Central line placement

Anesthesia Type (Circle): General Spinal Epidural ~~IV Sedation~~ Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP — EBL MIN
Meds/Times: 10 MSO4 25 Phenergan

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

Pre Op Meds History

Time	1205	1210	1215	1220	1225
SaO2	100	100	95	100	100
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140		✓	✓		✓
120	✓			✓	
100					
80		∧	∧	∧	∧
60	∧				
40					
20					
RR	17	14	15	16	12
T	96.4				
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	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	1	1
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	9

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 23 NOV 03

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

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

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	RLE	limited	+	P	B	WM	PK
15'	RLE	limited	+	P	B	WM	PK
30'	RLE	limited	+	P	B	WM	PK
45'							
60'							
90'							
D/C	RLE	limited	+	P	B	WM	PK

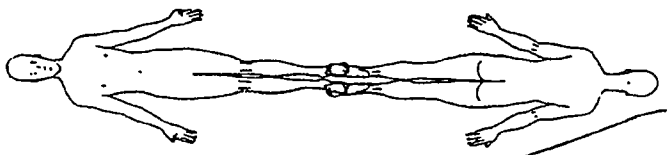
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1205	RLE	Kerlex	O
30' 1235	RLE	Kerlex	O
60'			
D/C 1235	RLE	Kerlex	O



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1205	NSR	O	O

WAMC OP 173-E

NURSING NOTES

Pt received from OR S/P I+L RLE and CC placement. SpO2 100% RA, no c/o pain. X-ray done of chest for CC placement. Pt being transferred to ICW. Report given to Lt [redacted] [redacted]

b(6)-2 A11

Discharge Criteria:
Date: 23NOV03 **Time:** 1235 **PARS:** 9
BP: 142/99 **T:** 96.4 **HR:** 95 **RR:** 16 **Sa02:** 100
Pain Level at D/C (0-10):
Intake: — **Output:** —
Additional Data: —
Transferred To: ICW.
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted] B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 25 NOV 03
Time In: 0930
Allergies: —
Pre-op V/S: 11/03 84
Procedures: I+D R Femur

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 450 Colloid
OR Output: UOP EBL MIN
Meds/Times: 5 Fent

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

Pre Op Meds History

Time	0920	0925	0930	0935	1000	1015
SaO2	100	100	100	99	98	100
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						✓
120					✓	
100	✓	✓	✓	✓	✓	✓
80	•	•	•	•	•	
60	^	^	^	^		
40						
20						
RR	11	12	12	11	12	14
T	98.1					

Time										
Pain (0-10)										

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1030	NS	100	IV		

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

[redacted] b(6) 2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 25 NOV 03

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

Name — last,

[redacted]

b(6) - 4

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

MEDICATIONS

Allergies:

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 fem	limited	+	+	B	wm	PK
15'	R fem	limited	+	+	B	wm	PK
30'	R fem	limited	+	+	B	wm	PK
45'	R fem	limited	+	+	B	wm	PK
60'	R fem	limited	+	+	B	wm	PK
90'							
D/C	R fem	limited	+	+	B	wm	PK

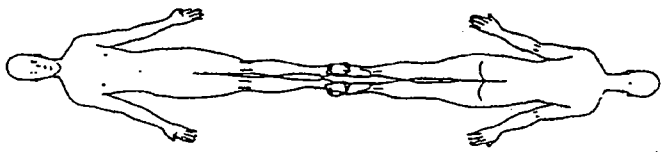
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 930	R Femur	Kerlex	0
30' 1000	R Femur	Kerlex	0
60'			
D/C 1030	R femur	Kerlex	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
930	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR S/p I&D right femur. Pt SpO2 100% RA, no c/o pain. Pt unarousable to verbal. 30 minutes (1000) after arrival pt still not arousable to verbal/pain. 45 minutes (1015) after arrival pt arousable to verbal. Report given to Lt [redacted] SpO2 100% no c/o pain VSS - [redacted] LPN

b/w 2 A11

Discharge Criteria:
Date: 25NOV **Time:** 1030 **PARS:** 9
BP: 137/108 **T:** 98.4 **HR:** 107 **RR:** 11 **Sa02:** 100%
Pain Level at D/C (0-10):
Intake: 100cc **Output:** —
Additional Data: —
Transferred To: ICW,
Report Given To: Lt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 28NOV03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1348

Allergies: —

OR Intake: Crystalloid 500 Colloid

Pre-op V/S: 123/79 118 OR Output: UOP — EBL min

Procedures: TFD (R) LE Meds/Times: Long MS04, 25 Phenergan 2.4 Fent

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

Pre Op Meds History

Time	1348	1353	1358	1403	1410
SaO2	100	100	100	100	100
FiO2					
Methods	RA	RA	RA	M	M
RR	10	10	10	10	11
T	97.4				

240 / 220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

Time					
Pain (0-10)					
LOS					

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

Codes

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

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

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

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

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

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 28NOV03

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

Name — last,

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

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	RLE	limited	+	P	B	WM	PK
15'	RLE	limited	+	P	B	WM	PK
30'	RLE	limited	+	P	B	WM	PK
45'							
60'							
90'							
D/C	RLE	limited	+	P	B	WM	PK

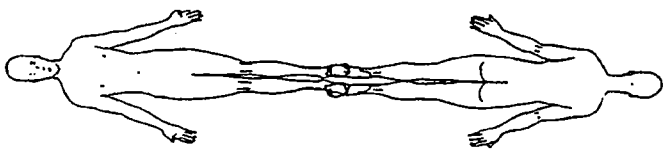
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1348	RLE	Kerlex	0
30' 1418	RLE	Kerlex	0
60'			
D/C 1430	RLE	Kerlex	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1345	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p RLE I+D, SpO2 100% RA. Pt unarousable to verbal or pain upon arrival. Pt arousable to verbal 30 min. after arrival. Report given to Lt [redacted] No c/o pain SpO2 100% — [redacted] LPN

b(6)-2 A11

Discharge Criteria:
Date: 28NOV03 **Time:** 1430 **PARS:** 9
BP: 142/107 **T:** 96.0 **HR:** 101 **RR:** 14 **SaO2:** 100
Pain Level at D/C (0-10): —
Intake: — **Output:** —
Additional Data:
Transferred To: Lt [redacted]
Report Given To: ICW
Transferred Via: W/C Litter (Gurney) Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP: [redacted]
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date): 11

Date: 02 DEC 03 — Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1130

Allergies: NKDA — OR Intake: Crystalloid 400 — Colloid Ø

Pre-op V/S: 115/77 115 — OR Output: UOP Ø — EBL ≤50

Procedures: STSG to (B) legs I&D BSW — Meds/Times: 1mg versed 250 mcg fentanyl 7mg morphine

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

Pre Op Meds History

Time	1130	1135	1140	1145	1200	1215
SaO2	97	99	99	99	100	98
FiO2	RA	RA	RA	RA	RA	RA
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140	✓	✓	✓	✓	✓	✓
120	•	•	•	•	•	•
100		^	^	^	^	^
80	^					
60						
40						
20						
RR	24	15	18	15	22	14
T	98.6		98.7		98.1	98.0

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1130	LR	TKO	(1) subclavian L sheath		200

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	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

Time	Patient teaching done; Wound Care, Pain Management,
Pain (0-10)	T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS	Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] FC 91WM6 b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 02 DEC 03

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

[redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDICATIONS

Allergies:

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	(B) LE	⊕ x2	⊕ x2	⊕ P	≤3sec x2	warm	Pk
15'	(B) LE	⊕ x2	⊕ x2	P	B	Warm	Pk
30'	(B) LE	⊕ x2	⊕ x2	P	B	Warm	Pk
45'							
60'							
90'							
D/C	(B) LE	⊕ x2	⊕ x2	P	B	warm	Pk

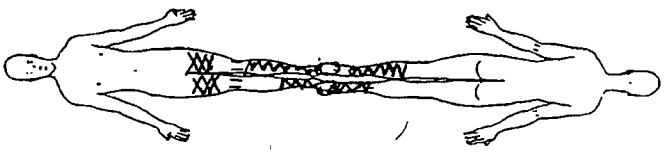
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(B) LE	Kerlex wrap / cast (R)	CDI
30'	(B) LE	Kerlex wrap / cast (R)	CDI
60'			
D/C	(B) LE	Kerlex wrap cast (L)	Small drainage



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1130	NST	NO	NO

NURSING NOTES

125 pt recieved from OR @ 1130 @ 1135 pt Alert
pull oral & nasal airway pt is cooperative
VSS ẋ̄ T 95.0 recheck @ 95.7 pt has
Kerlex wrapps on (L) calf & thight
Cast and Ex Fix on (R) calf, kerlex and
ex Fix on thigh c̄ slight drainage at present
No signs of acute distress noted will continue
to monitor [redacted] PC signature

b(6)-2 All

Discharge Criteria:
Date: 02 Dec 03 Time: 12 PARS: 10
BP: 126/99 T: 96.8 HR: 89 RR: 12 Sa02: 99
Pain Level at D/C (0-10):
Intake: 200cc LR Output: Ø
Additional Data: none
Transferred To: ICW 1
Report Given To: Lt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: PC [redacted]
Cleared IAW Recovery [redacted]
Nurse Signature [redacted]

WAMC OP 173-E

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: 06 Dec 03
Time In: 0930
Allergies: NKDA
Pre-op V/S: 115/75 110
Procedures: I&D ⊕ L E

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid
OR Output: UOP Ø EBL MIN
Meds/Times: 125mcg Fentanyl

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

Pre Op Meds History

Time	0930	0940	0950	1000	1010
SaO2	99%	100	100	100	100
FiO2					
Methods					
240					
220					
200					
180					
160					
140					✓
120	✓	✓	✓	✓	
100	•	•	•	•	^
80	^	^	^	^	•
60					
40					
20					
RR	16	20	18	16	16
T	98.7				

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

Codes

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

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

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

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

PREPARED BY (Signature & Title): b(6)-2 [redacted] AFC 9/1/06

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 06 Dec 03

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

b(6)-4 [redacted]

☐ 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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(B)LE	(+) x2	(+) x2	P	B x2	W	PK
15'	(B)LE	(+) x2	(+) x2	P	B x2	W	PK
30'	(B)LE	(+) x2	(+) x2	P	B x2	W	PK
45'							
60'							
90'							
D/C							

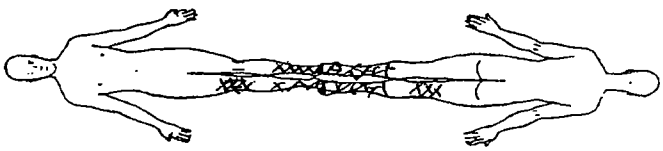
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(B)LE	Kerley wrap	CDI
30'	(B)LE	Kerley wrap cast	CDI
60'		Ex Fix	
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

0950 pt recieved from OR S/P I&D (B)LE
pt VSS T @ 95.8 SPO2 @ 100 on RA — [redacted] PFC SLNR
1000 pt VSS dressing CDI Nuesa ✓ (+) will
give report to ICW — [redacted] PFC SLN
b(6)-2

Discharge Criteria:
Date: 06 DEC 08 **Time:** 1000 **PARS:** 9
BP: 145/102 **T:** 97.4 **HR:** 105 **RR:** 10 **Sa02:** 100
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: None
Transferred To: ICW2
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: PFC [redacted] SGT [redacted]
Cleared IAW Recovery Room SOP B-3
Signature: b(6)-2

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: 10 DEC 03
Time In: 0435
Allergies: NKA
Pre-op V/S: 122/77 82
Procedures: I+D (R) LS
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP EBL
Meds/Times: Fentanyl, Versed

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	0435	0440	0445	0455	1000	1025	1040
SaO2	99	100	96	97	99	100	100
FiO2							
Methods	RA	RA	RA	RA	RA	RA	RA
240							
220							
200							
180							
160							
140				✓			
120	✓	✓	✓		✓	✓	✓
100	^	^	^	^	^	^	^
80				^			
60							
40							
20							
RR	20	22	20	22	20	20	18
T	96						
Time							
Pain (0-10)							
LOS	[redacted]						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	1
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

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

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

(Continue on reverse)

[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10 DEC 03

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

[redacted]

b(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0955	—	MSO4 2mg	IVP	—	[redacted]	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	LROM	+	+	B	C	PK
15'							
30'							
45'							
60'							
90'							
D/C							

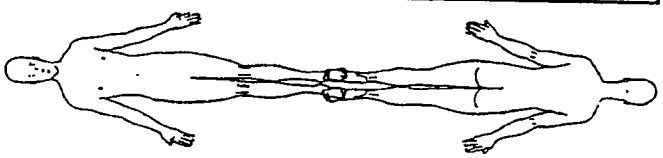
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	Lt fix C gauze + UP	
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0935	SR	∅	∅

WAMC OP 173-E

NURSING NOTES

Pt to Recovery Room from OR s/p HD (R) leg. Ext fix x 2 C SP drain + Kinlex to (R) leg. Kinlex to (L) lower extremity. Central line in place + IV fluids. Will continue to monitor. — [redacted] RN

0935 - Pt c/o pain, Medicated C 2mg MSO4. — [redacted] RN

b/c) - 2 A/1

Discharge Criteria:
Date: 10 DEC 03 **Time:** **PARS:** 9
BP: 131/90 **T:** **HR:** 94 **RR:** 22 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: ∅ **Output:**
Additional Data:
Transferred To:
Report Given To: ICW #2
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

b(2)-2

Admission and Coding Information

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

1. Reporting MTF	2. MTF L[illegible]on			
[redacted]	IZ			
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]			FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1990-01-01	13Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			06:35	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
NO	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS		19. Trauma	Prev. Admission
			DIS	NO
20. Source of Admission	Ward:		Name / Relationship of Emergency Addressee	
Direct from ER	ICW1		Address of Emergency Addressee	
[redacted]			Telephone Number of Emergency Addressee	
21. Type of Disposition	22. MTF Transferred To		23. Date of Disposition (YYYYMMDD)	
TRF-OTH			2003-12-20	
24. Clinic Svc - Admitting	25. MTF Transferred From		26. Date this Admission (YYYYMMDD)	
AEA - ORTHOPEDICS			2003-11-12	
27. Location of Occurrence	28. MTF of Initial Admission		29. Date of Initial Admission	
			2003-11-12	

b(2)-2

b(6)-4

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: OPEN R FEMUR/TIBULA FX

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Officer (Signature, as required) [redacted]

Signature of Admitting Clerk [redacted]

QUALITY ASSURANCE/RISK MANAGEMENT DOCUMENT

For use of this form, see AR 40-68; the proponent agency is the OTSG.

Prepare this form according to instructions on the reverse side to document events which may have quality assurance/risk management implications involving patients, visitors or other persons.

1. Date of Event	2. Time of Event	3. Location	4. Age	5. Sex	6.	7. Attending Doctor
17NOV03	0950		24	F	☑ INPATIENT ☐ OUTPATIENT ☐ EMERGENCY ROOM ☐ OTHER (explain below)	

8. DIAGNOSIS(ES)	9. POST OP DAY
Mn (D) femur + Tibia Fx	

10. TYPE OF OCCURRENCE/INCIDENT (check one only)		11. CONDITION AFTER OCCURRENCE		Narrative (optional):
	Adverse Drug Reaction (see instructions)		No Apparent Effect	
	AMA/Walkout (see instructions)		Minor Injury or Effect	
	Blood Transfusion (see instructions)		Significant Injury or Effect	
	Equipment		Death	
	Fall/Found on Floor (Prescribed activity level:		Other (explain in narrative box)	
	Laboratory			
	Medication (to include IV)			
	Pharmacy			
	Practice/Procedure Variance (staff)			
	Property Loss or Damage			
✓	Other (explain) Needlestick			

12. ACTION TAKEN	YES	NO
Doctor Notified	✓	
Did Doctor see Patient		✓
X-Rays ordered/taken		✓
Reported to Supervisor/Department Chief	✓	
Laboratory tests ordered/taken	✓	
Other (explain in block 14)		✓

13. WITNESSES ☑ NONE ☐ Yes (complete boxes below)

a. Name(s)	b. Duty Section or Home Address	c. Phone

14. DESCRIPTION OF EVENT (Concise, Factual, Objective Statement)

Purging line for IV med on pt. 1289. IV line had needle at end of tubing. P purging line, grabbed end of IV line + was stuck by needle at end of IV tubing.

Followed up in OPC immediately P needle stick. Bld drawn. Pt's blood drawn also c̄ physician order — Spaceman

If more space is needed, use a continuation sheet.

15. Name/Grade, Title of Individual Completing Form (print)	16. Signature	17. Date of Report
[redacted] MLT/AN	[redacted] 22/AN	17NOV03

18. PATIENT ID PLATE OR PRINTED NAME AND SSN

blew-2

[redacted]

blew-4

The information placed on this form is confidential and privileged IAW 10 U.S.C. 1102.

UNAUTHORIZED DISCLOSURE CARRIES A $3,000 FINE.

DO NOT FILE OR REFER TO THIS FORM IN PATIENT RECORD. REPORT EVENT TO SUPERVISOR/DEPARTMENT CHIEF IMMEDIATELY.

FOR QA USE ONLY

19. Log Number _____

20. Further analysis indicated NO ☐ YES ☐

b(6)-2

[redacted]

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

DATE OF DISCHARGE	TIME OF DISCHARGE
12/17/03	

SIGNATURE OF WARD OFFICER

[redacted] b(6)-2 SGT 9/WM

PATIENT'S IDENTIFICATION

ACTIVITY CLEARANCE [redacted]

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR
17 DEC 03	[redacted] b(6)-2

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 P[illegible]CES DA FORM 6-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	[redacted]	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	32Y	X	MUSLIM			NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]		ICW1

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER			Inj

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	06:35	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2004-01-24

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-12	[redacted] b6-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-12	

31. Selected Administrative Data

Marital Status: DoB: 1971-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: MVA

34. Diagnosis / Operations and Special Procedures:

R LEG EX FIX, 5TH DIGIT AMP

Dx:
823.10
886.10
821.31
816.10
890.0
E 991.9

Px
81.47
83.82
86.69
79.35
93.59
8016 (x 4)
77.19
77.15
83.09
99.29
88.27
88.26

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	65	65

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	65	65

Signature of Attending [redacted] b(4)-2 Signature of RAD or Medical [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

31 YO M, SODT IN VEHICLE AT CHECKPOINT, TREATED AT 782ND FST. (R) OPEN DISTAL FEMUR, (R) OPEN TIBIAL PLATEAU FX, SPRAINED X-FIX. ALSO (R) GSW AMPUTATION

PMH - KIDNEY PROBLEMS - ? STONES

ROS (-)

NKDA

PHYSICAL EXAMINATION

HEENT - SMALL FACIAL WOUND

NECK SUPPLE

CHEST - AT/NL

ABD - SOFT BOWEL - WNL

EXT - (R) LEG SPRAINING X-FIX

DIMINISHED DISTAL.

MANY FOGS WITH. SENSATION INTACT GROSSLY.

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

X-RAYS - COMMINUTED (R) DISTAL FEMUR PLATEAU, LEGISMINUS (R) LATERAL CONDYLE FEMUR FX

(1) OPEN (R) KNEE FRACTURES

(P) NEEDS IV ABX

[redacted] b(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	12 MAR 03		

PATIENT IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO
[redacted] b(6)-4		

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR, 201-45.5)
OCTOBER 1975
USAPPC V1.00

b(2)-2

[redacted] Trauma Flo Sheet

Name: EPW #2 SSN Unit

Blood Type

Date and time of injury: 11 Nov. Time of Arrival 2358

MOI: GSW / multiple

HPI:

PMHX:

PSHX:

Meds:

Allergies:

Primary Survey

Airway: Patent Mechanically maintained by

Breathing: Spontaneous Assisted by

Circulation:

Pulse: Present Absent CPR

Color: Normal Abnormal

Cap refill: Normal Delayed

Secondary Survey

Intial Vital Signs: b/p 119 / 86 pulse 103 Resp 36 Pulse Ox 100 Temp

GEN:

HEAD:

NECK:

HEART:

LUNGS:

CHEST:

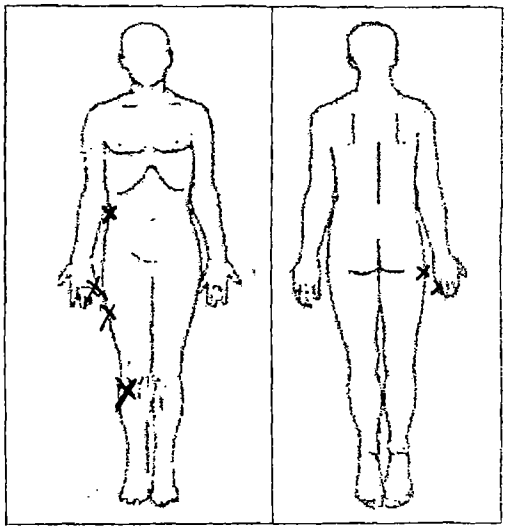
ABD:

PELVIS:

EXT: LR extremity wound ; UR extremity

RECTAL: no gross blood on DRE

NEURO:



GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	

Interventions

Airway: patent, breathing - spontaneous

Breathing:

Circulation: Large Bore I.V. 1000 ml LR 14ga.
Foley given; 400cc output Foley Coll

Other:

MEDICATIONS

Time	Drug	Dose	Route	Initials
0005	Morphine	4 mg	I.V.	[redacted]
0007	Ancef	1 gm	I.V.	[redacted]
~~0014~~	~~—~~	~~400cc~~	~~—~~	[redacted]
0028	Morphine	3 mg	I.V.	[redacted]

b(6)-2

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
0008	119/82	97	26	99		
0012	127/72	85	34	100		
0020	127/72	81	23	100		
0026	135/79	84	35	100		
0031	146/82	90	27	100		
	/					

Transfer Instructions:

NOTES:

Prepared By:

MEDICAL RECORD	PROGRESS NOTES
DATE	

12 Nov 2003
0545

OPERATIVE NOTE

DIAGNOSIS: 1) Open (R) Distal Femur / Prox tibia Fx
2 (R) Thigh lacerations 3) (R) 5F Amputation

PROCEDURE: 1) I & D (R) knee & Spanning External fixator.
2) I & D (R) Thigh lacerations
3) Completion of (R) 5F Amputation

SURGEON: [redacted]

FINDINGS: Comminuted (R) lateral tibial plateau
Opened lateral arthotomy and irrigated knee.
Left penrose drain in joint.
(R) 5F - comminuted middle phalanx - excised. Closed soft tissue over prox phalanx

FLUIDS: 1000 cc LR EBL: 150 cc
500 cc Hespan UOP - 800 cc

b(6)-2 All

[redacted]

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12 NOV 03 1930	- Assumed care of pt responsive A+O VSS Trans from EMT Dx Fx to femur and Tibia ex fix in place wound are wrapped bleeding noted. Lungs clear O2 SAT 96% RA encouraged to d. breath HRRR Active BS. Foley to gravity CYU 1000 cc IN ER. PIV to (R) bicep region LR @ 125cc/hr IV AB x TX. c/o pain medicated c̄ relief. Minor abrasion to (L) LE knee and (L) side of face scab & ac bleeding will cont to monitor b(6)-2 [redacted]
12 NOV 03 @ 2105	assumed care of pt @ 1800. VSS. Alert, speaking Arabic. LS CTA; (+) BS, tol reg diet well; Foley draining clear yellow urine; RLE c̄ drsg from hip to ankle, saturated @ hip & calf, drsg reinforced c̄ abd pads & Kerlix. Ex-fix in place. (+) CMS to RLE, +2 DP, equal (bil). (R) UE drsg CDI, (+) CMS. unable to assess radial pulse d/t drsg. (R) UQ abd wound, 1.0 cm x 1.0 cm, draining sm amt serosang drainage. Through interpreter abd is obese, ↓ changes from prior to incident, ↓ abd pain. (R) ac IV c̄ LR @ 125cc/hr, patent, 2 pt restraints on ↓ S/Sx of skin/circulation compromise. Plan: monitor drsgs, NPO p MN, pain control. [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

#[redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 NOV 03	Assumed care pt. A+O x3. Denies pain or discomfort
0700	@ this time VSS Lungs clear HLRR x Active BS x4 quads
	Remains NPO on call for surgery today. PIV 14g @ brachial
	area patent LR @ 125 clear. Cont IV ASX TX Afebrile &
	s/s of infection. Dressing to @ LE Kerlix wrap reinforced
	Will cont to monitor [redacted] MC
13 NOV 03	Orthopedic Op Note
1305	
	Pre Op Dx: (1) (R) open knee tibial plateau related
	fragment sensitive fracture
	(2) Multiple GSW (R) leg
	(3) (R) SF amputation
	Post Op Dx: same
	Procedure: I+D (R) leg, dressing change (R) SF
	Surgeon: [redacted]
	EBL: min
	Findings: Wounds clean. Removed
	splinter in knee. Dystrophic skin flap
	over this area. Very large
	cavity wound (R) buttock. Irrigated
	all wounds with 6 liters. Buttock
	wound packed with moist dressing roll
	Plan: Repeat I+D in 48-72 hours
	[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

13NOV03 (2250) NSG - VSS. ⊖C/O pain. Pt went to OR for washout of (R) leg. Ex-fix in place, (R) leg wrapped c̄ kerlex + Ace bandage. Posterior area of knee dark, red blood soaked through DSG. ⊖order for DSG Δ. Reinforced DSG c̄ ABD pad + kerlex. Will continue to monitor site. Pt tol. DSG reinforced. Pt has 5th finger, (R) hand amputated. DSG CDI. IV (R) AC, infusing IV ABX. ⊕Foley drainin clear, yellow urine. Pt tol Reg diet. D/C LR. Pt H/L at this time. b(6)-2 [redacted] RDT/AN

(2300) (R) LE. ⊕2 pedal pulse, brisk cap refill, pt able to wiggle toes, warm to touch. b(6)-2 [redacted] RDT/AN

14NOV03 1503 Assume care of PT @ 0100. VSI, A+O. Ø c/o pain. Ex-fix intact, (R) leg wrapped in kerlix and ace bandage. ⊖orders for dress Δ, reinforce c̄ kerlix. Minimal leakage today. Maintains a distal pulse. Foley to gravity c̄ amber color urine. IV in (R) arm still intact. Will cont. to monitor. b(6)-2 [redacted] RW SPC

(1600) I concur. b(6)-2 [redacted] WAS

15NOV03 (0030) VSS. (R) leg ex-fix intact. Reinforced ABD pad + kerlix has dried blood. ⊖Signs of active bleeding. ⊕2 pedal pulse in (R) LE. Warm to touch + pt able to move toes B/L. (R) 5th finger amputated. DSG to (R) finger 5th CDI. ⊖C/O pain. Pt H/L 2°

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.(

b(6)-4
[redacted]

MEDCOM - 24120

b(6)-2 AT unless noted dif.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) pt tol po well. Pt aware that NPO p MN for O.R. in AM. ⊕ Foley draining clear yellow urine. Continuing IV ABX. IV to (R) AC intact c̄ ⊖ SISx of infection. — [redacted] T/AN
15 NOV 03	Assume care of PT @ 0600. VSS, AOx3 went to OR this
1750	morning for (R) Tib-Fib. No longer does he have an ace bandage around (R) leg, just kerlix. Reinforced the kerlix c̄ more kerlix. Ex-fix site still intact ∅ signs of infection, bleeding through kerlix. Foley to gravity clear yellow urine. No signs of bleeding at PT (S) F site. 2pt restraint without any skin irritation. Will cont. to monitor. — [redacted]
15 NOV 03	VSS AOO. (R) LE c̄ Extrafixit. Ren dits without
2000	drainage or crustation. Kerlix dry to (R) LE dry & intact. Pedal pulses +2 bilaterally. Capillary refill brisk to toes (B). Foley to gravity draining clear yellow urine. (R) PA Saline lock patent & intact. +2 Restraints applied without compromising circulation or skin integrity. Will continue care as planned. — [redacted] TAN
16 NOV 03	Assume care of PT @ 0600. VSS, AOO c/o ∅ pain today.
1634	Foley to gravity c̄ clear yellow urine. Ex fix intact area has minimal drainage. ⊖ orders to Δ dress, reinforce with kerlix and check. Washed PT down and brushed teeth. In 2pt restraint ∅ skin breakdown. Will cont. to monitor. — [redacted]
1700	c/o pain given two percocets. Will cont. to monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

b(6)-4

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

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

15 Nov 03
DSS

On the Op Note

Pre Op Dx: (1) Open (R) tibial plateau fracture in spanning x-fix.
(2) GSW (R) buttock
Post Op Dx: same
Procedure: I&D and DPL of wound
Surgeon: [redacted]
FBL: MN
Findings: Wash clear. Longitudinal fibula closed over Penrose drain.
PLAN: NWB x 8 wk. Let wound heal. Consult prosthetics service to (R) shield frame and spacer tibia. Will get CT. Scan pre op [redacted]

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.

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

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16 ~~0~~ 0700	VSS A&O. (R) LE c Ex-fix in place (R)
0700	Pedal pulse +2. (R) Toes capillary refill brisk. (R) LE wrapped c kerlix which is dry & intact p temporary drsg to back of thigh c cuvlene drsg & wrapped c kerlix. Foley care done. Foley draining clear yellow urine. (R) FA Saline lock patent & intact. Consumed 60% of ~~dinner~~ dinner. +2 Restraints applied within compromising circulation or skin integrity. Will continue care as ordered. b(4)-2 [redacted]
17 Nov 03	Pt A&Ox3, VSS pt c/o mild pain from (R) leg
1240	ex-fix site, left leg drsg removed drsg with cuvlene and right forearm alone accessible. Pt voided 700cc dark yellow urine, via foley. IV intact patent (R) antecubital. Restraints x2 in place (R) circulation. [redacted]
17 Nov 03	I concur c above assessment. Drsg to pt's
1600	(R) 5th finger CDI. Will continue to monitor — b(4)-2 [redacted]
18 Nov 03 @ 0500	Assumed care @ 1800; VSS, pt A&O speaking arabic, c/o pain; Ex-fix to (R) LE in place, dsg CDI, No orders for dsg Δ; (-) drainage, (+) cms, +2 PP, brisk

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

[redacted]
b(4)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) cap Ref to affected leg; FTG draining QS clear dark yellow urine; S/L patent, cont ⊖ IV abx; Restraints in place, ⊕ circ ⊖ skin break ✓; cont to monitor [redacted]
18 NOV 03 0700	- Assumed care of pt. A+O x3. VSS ⊖ c/o pain at this time. Lungs clear Bedrest shallow breathing incentive spirometer at bedside. AM care given. HRRR Active BS. Tolerating PO well. Foley to gravity amber urine QS. IV ABX TX cont ⊖ evidence of skin breakdown noted. PIV (L) wrist 20 gauge patent SL Afebrile ⊖ s/s of infection will cont to monitor [redacted]
19 NOV 03 0500	Assumed care @ 0500; VSS, pt A&O speaking arabic, ⊖ c/o pain; Ex-Fix in place - ⊕ CMS +2PP, brisk cap Ref; dsg CDI, ⊖ drainage; pt voided 275 cc/h. clear, dark yellow urine @ 2100 ⊕ 1700 foley pull [redacted] S complications; pt remains on BR, IS @ BS, enc. Q1° whiteamake; pt TOI Reg diet well; S/L to (L) wrist patent, easily flushes, cont ⊖ IV abx; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor [redacted]
19 NOV 03 0700	- Assumed care of pt. A+O x3. VSS Denies having pain or discomfort @ this time Lungs are clear HRRR Active BS x4 Tolerating PO well. External fixator to (R) LE intact pin care given dsg changed to (R) buttock Dry 4x4 dsg and (R) thigh 4x4 kerlix wrapped. IV ABX TX ⊖ s/s of infection Afebrile Will cont to monitor [redacted]
19 Nov 03 2113	Pt care Assumed @ 1800. Pt A&O speaking little English. VSS c/o pain to (R) LE. 2 percocets given. LS CTA (B) HRRR. ⊕ BS x 4 quads. Abd soft Flat nontender. Ex fix to RLE in place & intact. Bloody show appears on mid anterior of thigh Dsg. Dsg reinforced. Will cont

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b(6)-2 All

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

11 Nov 2003

~40 yo ♂ s/p multiple GSW's to (R) LB, (R) Hand. Arrives awake & alert. Has superficial wound to (R) flank. Examined & cleared by Gen Surg

PE (R) LE - NL DP/TP pulses. Able to move toes to command.
5 x 7 cm wound on lateral knee, obvious bone fragments
2 wounds to (R) upper thigh.
(R) Hand - Traumatic Amputation (R) SF
Xrays - 1) (R) Distal femur & proximal tibia fx
2) (R) SF amputation, fx of prox phalanx
AP Pelvis - No hip fx. ⊕ metallic fragments

(A/P) 1) (R) Open knee & distal femur & prox tibia fx
2) (R) SF amputation
3) (R) thigh soft tissue wounds

Bed

DKW-2

[redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	[redacted]	INTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELAT[redacted]	

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

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

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Nov 03 Cont.	to monitor. [redacted] Spc 91WM6
20 NOV 03 @ 1040	Pt alo, VSS (temp 99.2), HRRR LCTAB, (+) BSX4 qd. ex fix intact (R) leg drsg D&D, bloody drainage to drsg from small wound. dried blood to pin sites, area cleaned, pin care done. (+) pedal pulses to (B) feet. brisk cap refill. Medicated c̄ 1 Percocet for pain. IV Dent & Ancef con't per MD orders. Drsg to (R) buttock D&D, sero-sang. drainage, moderate amt. 4x4 applied. Pt tol 50% breakfast this AM. 2 pt restraints on ~~s~~ compromise to skin / circulation. Plan: amb c̄ crutches, rev Abx, pain ctrl. Will monitor ([redacted] LPN —
20 Nov 03 1707	pt consult walked pt [redacted] / crutches weight as tolerated pt SBA SPC [redacted] SPC
20 Nov 03 1800	19 Alo VSS. Ex fix to (R) LE In place c̄ Intact Drsg CDI. Stump to (R) Hand pinky Drsg CDI. Incision closed c̄ sutures no drainge noted. LS CTA (B), S1, S2 present HRRR, (+) BSX 4 quads. Pain controlled c̄ percocet. [redacted] / cont to monitor [redacted] Spc 91WM6
21 NOV 03 1615	Pt alo, VSS, percocet given for pain, drsg D&D, small amt bloody drainage, pin care done, buttock drsg saturated c̄ sero-sang drainage (D&D early this AM). ambulated c̄ PT earlier today. IV Abx con't. LCTAB, (+) pulses to extr. Will monitor [redacted] LPN.

b(6)-4

[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 Nov 03 2300	Pt A&O $S_1 S_2$ present HRRR, LS CTA (B). EX Fix to (R) LE. Drsg CDI. Drsg to Buttocks saturated c̄ Sero Sang fluid. Δ'd @ 1930 hours. Pt voids spontaneously ~~via~~ c̄ ru s̄ difficulty. c/o pain controlled c̄ percocet. Will cont[redacted] to Monitor. b(4)-2 [redacted] See 9/WMG.
22 Nov 03 (1550)	Assumed care @ 0800. Pt alert, speaking Arabic VSS. Pain controlled c̄ Percs. Pt OOB to amb in hallway c̄ crutches. Personal hygiene done in BR. Ex fix in place on RLE. Pin care done. Dsgs on (R) thigh and (R) shin Δd. Wound draining sm. amount sero-sang drainage. SL in (L) forearm dlcd d/t infiltration. catheter intact. 18 g IV started in (L) hand flushes well s̄ S/Sx infiltration. Tol. reg diet well. Voiding s̄ difficulty 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. b(4)-2 [redacted]
22 Nov 03 1900	VSS. (R) LE c̄ extend fix in place. Pin sites without drainage or crustation. dry to (R) LE dry to touch (L) hand Saline lock patent/intact. ~~Dorsalis~~ Dorsalis pedis pulse palpable +2. 2 restraints in place without compromise

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

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WARD NO. CU 71

PROGRESS NOTES
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b(4)-4
[redacted]

MEDCOM - 24127

b(6)-2 All unless noted differently

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22NOV03 (1900)	circulation or skin integrity [redacted] 24 Hr —
23NOV03	(PM) Assumed care @ 0900. Pt alert, speaking Arabic. VSS. Ø c/o pain @ this time. Pt amb c̄ crutches in hallway s̄ difficulty. OOB to chair - tol. well. Amb to X-ray this pm. Tol. well. Ex. fix. in place on RLE. Pin care done c̄ ½ H_2O_2. Dsgs to @ thing [redacted] thigh and shin Δd. wounds draining sm. amount sero-sang drainage. 2-point restraints in place ō s/sx complications. SL in @ hand flushes well s̄ s/sx infection/infiltration. will continue to monitor. [redacted] 4
23NOV03 1900	VSS. ~~(L) [redacted]~~ (L) hand saline lock patent + intact. (R) 5th finger amputee c̄ sutures intact ~~wound~~ edges well approximated w. incision. (R) LE w/ch external fix in place. Pedal pulses +2. Toes cap/blanching refill brisk. (R) LE ext fix pin site without drainage or redness. Voiding clear yellow urine. Consumed 80% of regular diet for dinner. Percocet effective for pain management. 2 point restraints in place without compromising skin integrity or circulation. — [redacted] CT 4
24NOV03 1600	Assumed care of pt. @ 0900. VSS, A&O. Ø c/o pain. Pin care done; dry dressings to (R) knee & buttocks, mod. sero-sang. drainage. Visited @ bedside CTU. ⊕ BS all 4 quads. Pt. in 2-point restraints, Ø signs of ~~skin~~ breakdown. All other assessments WNL. [redacted] 2CT, RN

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[redacted]

b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25NOV03@0500	Assumed care @1800; USS, pt A&O speaking arabic; Ø c/o pain; Pt OOB to BR c̄ crutch assistance c̄ difficulty; Ex-Fix to (R) LE in place, dsg CDI Ø drainage Noted; pt voiding Qs, clear yellow urine via urinal, pt TOL Reg diet well; S/L patent, Flushing well c̄ s/sx infection/infiltration; cont c̄ IV abx; Restraints in place, Ø circ, Ø skin break ↓; will cont to monitor b(6)-2 [redacted]
25 NOV 03	Assumed care @0600 pt awake and oriented x 3, UUS, pt has Ø c/o pain at this time. PIV care and dsg Δ complete (W→D), some reddish drainage from wound and small amount of greenish pus easily wiped from wound site. Pt voiding via urinal. Restraints x2 in place, Ø PP, Ø circulation, Ø skin breakdown, will monitor. Pt ambulates with some difficulty and c/o pain. [redacted] Concur c̄ Above (1800) b(6)-2 [redacted]
26 Nov 03@ 0430	Assumed care @ 1800; USS, pt A&O speaking arabic, Ex-Fix in place, dsg CDI Ø drainage; ⊕ CMS +2PP brisk cap ref, NV intact to affected leg, Ø c/o pain; pt NPO P̄ MN for OR on 11/26; Restraints in place, ⊕ circ, Ø skin break ↓, cont to monitor b(6)-2 [redacted]
26 NOV 03	Assumed care of pt @0600 pt awake + oriented x3, UUS, pt. has Ø c/o pain at this time, PIV care and dsg Δ complete (W→D) reddish green drainage from buttocks (cont)

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

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b(6)-4 [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 Nov 03	(Cont) drsg, ~~pincer~~ and ⓡ knee wound exhibiting some reddish drainage. Pt completed all core, awaiting surgery. Restraints x2 in place ⊕ circulation. b(6)-2 [redacted]
26 Nov 03 2030	Recieved pt @ 2035 hours from PACU. Pt A&O and c/o of severe Pain. Pt had received 10 mg of MSO4 in PACU prior to transfer to ICW 1. Ⓑ LE Drsg c̄ Ace Wrap CDI. Drsg to ~~Ar~~ Posterior Ⓑ Flank CDI. LS CTA Ⓑ, HRRR. ⊕ BS x4 quads. Pt has LR @ 150 cc to 18 G to Ⓡ FA. Pt Not taking H_2O in because he's ostep. Will D/C in AM. Will cont to monitor [redacted] Spec 9 IW/MG
27 NOV 1045	Pt a10, temp 99.4, Ø c10 pain expressed, LCTAB, HRRR, ⊕ BS x4, Ⓡ LE c̄ drsg & ace wrap. CDI, JP drain intact, output recorded on DD792. Drsg to Ⓡ flank CDI. Pt tol breakfast well, now heparlocked. foley to gravity draining cyu. IV/Ident & Ancep cont per MD orders. Ⓡ toes c̄ brisk cap refill, warm & pink. Plan: enc IS, enc PO, ~~amb c̄ crutches~~, OOB TO CHR. Will monitor b(6)-2 [redacted] 9IW/MG,
1725	VS: 100.9, 93% RA, P: 105, R: 20, 110/61 [redacted] LPN.
1735 [redacted]	[redacted] informed of pretransfusion VS. Order given to continue transfusion but premed c̄ 650mg po tylenol. Blood verified Unit W0 W0016 03003835 started c̄ Y tubing. Premed c̄ Benadryl 25mg. Procedure explained by interpretor. b(6)-2 [redacted] LTC, ar
Transf started @1743.	
~~1650~~ (1750)	VS: 107/61, P: 103, R: 22, O2 sat 93% RA, Temp. 100.4 Ø reaction noted. b(6)-2 [redacted] LPN —

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[redacted] b(6)-4

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

26 Nov 03 Ortho Op Note

Pre Op Dx (2) (R) bicondylar tibial plateau fx
(2) (R) tibial plateau fracture
Post Op Dx - Same
Procedure ORIF (R) tibial ~~bicondylar~~ bicondylar fracture
Surg - [redacted] b(4)-2
EBL 500 cc
Drains JP
Findings: Severe loss of lateral tibial plateau articular surface with displacement. Multiple metaphyseal fragments removed from fracture site and posterior knee joint. Filled with large plate stability, 3 6.5 cancellous screws, screw sandwich. Good reduction after plateau, size restoration of medial condyle, arthroscopic analysis.

BW-2 [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVI[redacted]NED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

[redacted]

b(4)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27Nov03 1850	VSS 97/58 HR 99 Temp 100.3 SPO_2 95%. Pt is A&O. Eating Dinner. LS CTA(B), 15 x10 per hour. HRRR. Pt is infusing 2units of Blood via 18G to (L) hand. JP to RLE intact and inplace to Bulb suction. (B) LE in Drsg c̄ Ace Wrap CDI. Denies pain at this time. 20G Hl To (R) wrist. Voids spontaneously c̄ ~~[illegible]~~ c̄ difficulty. Will cont to monitor. b(6)-7 [redacted] Spec9 IWM
1945	Pt consumed 95% of Dinner b(6)-2 [redacted] Spec9 IWM
2030	Blood trans 1st unit completed. VSS ~~[illegible]~~ BP 123/2[illegible] HR 107, SPO_2 94%. Temp 100.7°F O [redacted] b(6)-7
2035	Start second Unit of Blood, VS' BP 118/66, HR 109, SpO_2 93% Temp 101.0°F O. Will cont to monitor
28 Nov '03	Pt awake oriented x3, VSS temperature Nightly elevated 101.0, pt c/o of pain given 2 pcs ~~[illegible]~~, IV left hand patent and intact, foley to gravity, JP drain intact, restraints x2 IV dual ~~[illegible]~~ circulation ~~[illegible]~~ skin breakdown [redacted] b(6)-7
	(1810) I concur c̄ above assessment [redacted]
28Nov03 2000	Pt A&O VSS Denies Pain. Drsg to R Leg CDI. FTG Draining c̄ x u. JP to (R) leg with bulb suction ~~Draining~~ Drainage is sero sang fluid.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			b(6)-2 A1

DATE	NOTES
28 Nov 03 Cont	Pt consumed 70% of meal. Tol PO well. Will cont to Monitor. LS CTA (B) (A) BS [redacted] ts. HRRR. [redacted] c9 1NMb
29 Nov '03	pt awake + oriented x3, WN, pt tolerating P.O. well, with c/o abd gas, pt given 30cc Maloxt pt IV flushes easily through cath now, restraints x2 in place, (P) circulation, (S) skin breakdown, will monitor. [redacted]
	(1730) I concur c above assessment. UP pulled by MD this pm. pt tol. well. c [redacted] 2
29 NOV 03	VSS. ✗ Temp 101. Pt encouraged to use Incentive Spirometer. Used IS properly @ 900 cc/sec. Encourage P.O Intake of fluids. Percocet given for pain. Will monitor Temp. (P) LE ↑ on folded blankets. Pedal pulses T2 c̄ nail beds c̄ brisk capillary refill. (L) hand Saline lock patent & intact. Foley care done. Foley draining clear yellow urine. 2 point restraints [redacted] Will continue care as planned. [redacted] 27 NOV
30 Nov '03	Assumed care @ 0600 pt awake oriented x3, WN, pt HAS ∅ c/o pain at this time. (P) leg elevated awaiting post-op dsg Δ. (P) buttocks wound dsg changed some serosang and green drainage noted, pt tolerating P.O. well ∅ nausea, restraints x2 in place, (P) circulation (S) skin breakdown. will monitor. [redacted]
30 Nov 03 1430	I concur c above. New IV start, Heplock to (P) FA due to infiltrated [redacted] site. [redacted]

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MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
01 DEC 03 2000	Consumed 80% dinner. Foley draining clear yellow urine large quantity. Percocet effective for pain management. Dry dry & intact to (R) LE & buttock. Will continue care as planned. b(6)-2 [redacted] 20
2 Dec 03	- Assumed care of pt. A+O x3. VSS. Denies having pain or discomfort @ this time. Lungs clear IS and deep breathing encouraged. O2 SAT. now 90's c̄ deep breathing 96-98% RA. HLRR Active BS x4 quads. Urinating spontaneously c̄ difficulty IV ABX TX CONT. Wound (R) thigh dry dsg kerlix wrapped CDI. Will cont to monitor b(6)-2 [redacted]
2 DEC 03 2000	VSS Alert & Oriented. Lying on bed c̄ HOB↑30 (R) LE ↑ on blankets (folded). Pedal pulses +2 (B) Nail bed capillary refill brisk. (R) 5th finger staples c̄ sutures intact & edge well approximated. Dry dry & intact to (R) LE & buttocks. (R) FA Saline lock patent / intact. 2 point restraint applied without compromising circulation or skin integrity. Will continue care as planned [redacted] 20 b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD NO.

b(6)-4 [redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 NOV 03 (2000)	VSS Alert & Oriented. (R) FA Edema [redacted] intact & intact. (R) LE ~~E~~ ~~[illegible]~~ ~~fingers~~ [redacted] ~~in place~~. ~~pin sites~~ E dry dry [illegible] as well to buttocks. Foley to gravity drainage clear yellow urine. Consumed 50% of dinner. Percocet effective for pain management. Pedal pulses palpable +2 Bilaterally. Capillary refill brisk to nail beds of toes. Sutures intact to (R) 5th finger amputation stump. 2 point restraints in place without compromising circulation or skin integrity. Will continue care as planned. b(6)-2 [redacted] 2 LT AZ
1 DEC '03 0700	Pt AWAKE + oriented x3, Pt has ∅ c/o pain at this time. VSS, drsg to @ buttocks ∆'d some seeping drainage with a little green pus, sutures intact; IM care completed, pt c/o of pain (leg), awaiting ↓ post-op drsg change. Will monitor.
1000	~~Dr. Albertson removed splint~~, some seeping drainage [redacted] noted, pt encouraged to bed rest, drsg ∆'d with 4x4's gauze up and under and ace wrap. b(6)-2 [redacted]
1 DEC 03 2000	VSS Alert & Oriented (R) FA Edema bent patent & intact (R) LE Tim folded blankets. Pedal pulses (B) +2. Capillary refill to nail beds brisk —

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
		b(6)-2 [redacted]	4M
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.

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[redacted]
b(6)-4

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Dec 03	0200		- Assumed care of pt. A+O x3. VSS c/o pain when moving his (R) LE. Wound c̄ suture intact. Upper thigh wound Dry dsg CDI. Lungs clear HRRR Active BS Tolerating PO well. Foley d/c 0900 due to void 6° after pulled. Encourage ambulation c̄ crutches. Abdomen IV ASX TX cont. Will monitor [redacted]
3 Dec	1100		Pt ambulated c̄ crutches to BR for the first time. Tolerated OK c/o pain medicated c̄ percocets ii takes. Wound to (R) LE bleeding dsg to be changed [redacted]
3 Dec 03	1700		- Pt sleep @ this time. Will cont to monitor [redacted]
		2100	Assumed care of pt. @ 1800. VS - BP 118/68, HR-105, SpO2 93%, R-16, T-101.9. 1050mg tylenol given for temp. @ 2015. Temp. now 101.4. Will cont. to monitor. LS CTA(B), Resp. even unlabored, BSX4. Pt. voiding c̄ per urinal c̄ difficulty. dsg to (R) leg CDI. IV (L) AC (-) S/SX infl infiltration Pt. resting in bed @ this time c̄ two pt. restraints in place. ∅ comprise to skin. (+) skin integrity. Will cont. to monitor pt [redacted]

(Continue on reverse side)

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

REGISTER NO. [redacted] WARD NO.

NURSING NOTES
Medical Record

b(4)-2 A 11

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Dec 03		1200	Assumed care of pt. A&O x3. VSS Denies having pain or discomfort. Lungs clear HRRR Active BS x4 quads. Tolerating PO well. Urinating spontaneously per urinal. Crutch walked today per ward. Needing alot of encouragement and motivation. Dressing to (R) buttocks and (R) LE changed CDI staples intact open wound active bleeding dry sponge dressing and ace wrap applied. Afebrile IV ABX TX cont. Leg positioned in anatomic position. Will cont to monitor. [redacted] b(6)-2
DATE			
MEDICAL RECORD			

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5Dec03 0140	Assumed care @ 1800; VSS, pt alert speaking arabic; pain controlled c̄ percs; dsg to (R) LE CDI, ⊖ drainage; dsg to buttocks, CDI, ⊖ drainage; pt OOB to amb c̄ crutch assistance in hallway [redacted] against will; Tol well; pt TOL Reg diet; voiding ~~spontaneously~~ spontaneously c̄ difficulty, (R) Leg ↑, positioned anatomically; Restraints in place, ⊕ circ, ⊖ skin breakdown; cont to monitor [redacted] b(6)-2
06Dec03	(1600) VSS. ⊘ c/o pain. Amb to BR + did own AM care. Δ'ed Dsg to (R) thigh + buttocks. Dry DSGs. Staples in place on thigh. Serosanq drainage from 1" open wound. Packed c̄ fluff gauze. ⊕ 2 pedal pulse B/L. (R) Leg elevated. New IV started in (L) AC. 18G. IV ABX infusing c̄ difficulty. Will [redacted] continue to monitor. b(6)-2 [redacted]
05Dec03	Assumed care @ 1800. Pt c/o pain to (R) Leg. IV pain administered. LS CTA (B). HRRR ⊕ BS x4 quads. Drsg to (R) Leg CDI Distal lateral Drsg has 2inch ~~show~~ shadowing c̄ Sero Sang fluid. Drsg to Buttocks CDI [redacted] back to (L) AC 18G. Will cont to monitor. b(6)-2 [redacted] 91WM
06Dec03	(1400) VSS. C/O pain to (R) Leg. Med c̄ 2 perc. ↓ BS in bases. Amb ~~to~~ on ward c̄ crutches. Pt back in bed. Δ'ed DSG to (R) Leg. CDI. ⊕ 2 pedal pulse B/L LE, (R) Leg elevated. Tol. so well [redacted] Continue to monitor. b(6)-2 [redacted]

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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b(6)-4 [redacted]

PROGRESS NOTES
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NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6Dec03 6N	~~Assu~~ Assumed care @ 1800. Pt Denies Pain. Temp 100.2. 650 Tylenol administered. All other VSS. Pt LS CTA (B). (+) BS x 4 quads. 25% of meal consumed. Voids spontaneously c/o ↓ difficulty qs. HRRR. cont IV Abx via 18G in (L) AC. Drsg to RLE CDI. Drsg to [redacted] CDI. Will cont to monitor. — b(6)-2 [redacted] Sgt 9NMC
7Dec03 0830	VSS AFO. (L) AC Saline lock patent & intact. Consumed 40% of breakfast. Peripheral pulses palpable bil. (R) LE ↑ on folded blankets. Denies pain or discomfort @ this time. OOB ambulated c̄ crutches to BR. 2 point restraints in place without compromising circulation or skin integrity. — b(6)-2 [redacted] 2N
3Dec03	(0150) VSS x̄ temp 100. Will monitor. c/o pain. Med c̄ Percs 2. Lungsounds clear - ~~+~~ slightly ↓ at bases. (+) bowel sounds. Voids clear, yellow c̄ difficulty. Dry ~~dre~~ drsg to (R) Leg. CDI. ~~IV~~ IV Abx to (L) AC. Infuses c̄ difficulty. (+) 2 pedal pulse to (R) leg. Will monitor pain. — b(6)-2 [redacted] 20/DN

b(6)-4 [redacted]

Sorry! [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8 DEC 03 0920	VSS. AO. ∅ c/o pain @ this time. BS CTAB. BS ⊕. Laboratory PO well and voiding spontaneously clear yellow urine. BSG's intact to ⓡ leg and bathed. ⊕ pulses to ⓡ LE. FWB. Skin intact ∓ evidence of breakdown. Will to monitor. b(6)-2 [redacted]
8 DEC 03	(2345) VSS. c/o pain. Med ∅ 2 perc. Adequate Relief found. DBA to ⓡ leg CDI. ⊕ 2 pedal pulses B/L LE. HL to ⓡ AC. IV ABX infuses ∅ difficulty. Lung sounds clear through all lobes, slightly ↓ at bases. Voids clean, yellow ∓ difficulty. Will monitor. b(6)-2 [redacted]
9 DEC 03 1602	VSS. AO. To OR for revision of wound to RLE. Post-op VSS. RLE ∓ JP drain of BRB. BSG to RLE bar gauge wrap ∓ clear BSG over top. ⊕ pulses to all extremities. ↓ SCTAB. Feeling weakness prior to Sx. Verify light yellow urine ∓ difficulty. ∅ S/S of skin breakdown on patient. b(6)-2 [redacted]
1720	Drained 35 cc BRB from JP drain [redacted]
10 DEC 03 @ 0140	Assumed care of pt @ 1800. VSS. % pain to RLE, Percocets given ∓ good relief noted. RLE large opsite dressing gauze under opsite, CDI. JP attached ~~drainage~~ drainage sero-sanguinous drainage noted. (CONT [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR [redacted]
	LAST	FIRST	MI	(SSN or Other) b(6)-2

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

b(6)-2471

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 DEC 03 @0445	(CONT) ⊕ CMS to RLE, ⊕ PT pulse, equal bilat LE. Tol reg diet well, LS CTA, voiding clear/yellow urine ~ difficulty. 2pt restraints on ~ S/Sx of skin/circulation compromise. Plan: monitor drsg, monitor neuros, enc po, enc OOB, pain control. [redacted] CPT
10 DEC 03 @0600	JP output for night shift = 25cc. Total output last 24° = 60cc [redacted] CPT
10 DEC 03 1130	VSS. AO. HR. LS CTA. BS ⊕ x4. ⊕ pulses, CMS to RLE. Show IV placed to ⊕ forearm. Dp site & DSG intact to ⊕ leg. DSG ↓ to ⊕ bottom, pedal. Wound is pink ~ S/S infecto. Skin integrity is intact ~ compromise. Cont to monitor. [redacted]
10 DEC 03 @2000	JP output = 30cc. [redacted] CPT
11 DEC 03 @0100	assumed care of pt @1800. VSS. ↓ no c/o pain. ⊕ CMS to RLE. Drsg CDI to ⊕ femur, JP to bulb SXN ~ serosanguinous drainage noted. ⊕ DP pulse, equal BL. LS CTA, tol 25% of dinner meal, voiding per urinal QS. 2pt restraints on ~ S/Sx skin/circulation compromise. Plan: monitor pain control, monitor dressing, enc po intake. [redacted] CPT
11 DEC 03 @0535	JP output this shift = 20cc. Total JP output last 24° = 50cc [redacted] CPT
11 DEC 03 1730	VSS. AO. CR for washout. ⊕ pulse ⊕ CR ≤ 2 sec & CMS intact to RLE. BR & BRP for today. Rested well. ↑ PO intake. Light meal ate min QS. PERRLA. Oral [redacted] ~~Show IV place~~ RD

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12-9-03	OPNote
	PreOpDx: Infected (R) knee
	PostOpDx: SAme
	Procedure: I&D (R) knee
	Surgeon: [redacted] b(6)-2
	Esti: 0
	Fluids: 800cc
	Findings: Necrotic tissue tibial plateau
	Cx: 0
	PostOp Plan: Return to OR 48° b(6)-2 [redacted]
	OPNote
12-11-03	PreOpDx: Infected (R) knee
	PostOpDx: SAME
	Procedure: I&D (R) knee placement Abx beads
	Surgeon [redacted] b(6)-2
	Fluids: 1400cc LR
	Esti: none
	Cx: 0 b(6)-2 [redacted]

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12DEC03	(0220) Assumed care @ 1800. Pt ~~dented~~ [redacted] alert, speaking Arabic. VSSxt. Pain controlled c̄ Percs. Pt refuses to get OOBTC. ↑ to side of bed and then claimed to be dizzy. Dsg/ace wrap to RLE. CDI. RLE elevated on blanket. SL in ⊖ x dlcd d/t infiltration: catheter intact. IVFs SLd in IV in ⊕ wrist. ⊘ S/Sx infection/ infiltration. Tol. reg. diet well. Voiding ẽ difficult 2-point restraints in place ẽ S/Sx complications. Will continue to monitor. ~~b(6)-2~~ [redacted]
	(0300) Pt temp 101.5 this pm. medicated c̄ TT Percs, IS use encouraged. Pt temp 99' @ this time. monitoring. ~~b(6)-2~~ [redacted]
12Dec 03 0730	- Assumed care of pt. sleep yet easily arousable VSS A+O x3. ⊘ c/o pain or discomfort. Lungs clear O2 SAT 96-97% on RA. Incentive spirometer @ bedside. HCRN Active BS. Tolerated small amount of breakfast this morning. Encouraged PO fluid intake. Urinates spontaneously. ⊕LE dsg CDI ⊘ s/s of infection. IV ABX Tx cont. Will monitor ~~b(6)-2~~ [redacted]
13DEC03	(0245) Assumed care of pt @ 1800. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Dsg to RLE

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. ICW1

#[redacted]

b(6)-d

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV
Prescribed by SOAR/OSA SPMR (4150R) 191-11.0
US

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13DEC03	(cont) Ad c̄ Kerlix wrap. Dsg under wrap intact. Small amount of serosang drainage noted. RLE elevated on blanket. ⊕ pedal pulse equal bilat. Pt able to move toes. Pt OOB to chair. Amb to chair c̄ walker s̄ difficulty. Attempted to get back to bed x2 @ 2300. Pt claimed to be too dizzy to amb. Placed back in chair p̄ 2nd attempt to amb c̄ walker until 0215. Pt amb to bed s̄ difficulty c̄ walker @ that time. SL in ⊕ wrist dlcd d/t infiltration. catheter intact. 18g IV started in ⊕ hand flushes well s̄ slsx infiltration. Tol. reg. diet well. voiding s̄ difficulty. 2 point restraints in place s̄ slsx b(6)-2 complications. Will cont. to monitor [redacted]
13 Dec 03	Assumed care of pt. Sleep yet easily aroused AOX3
0700	VSS ⊕ c/o pain or discomfort. Lungs clear HRRR Active BS x4 quads. Urinated spontaneously per urinal GS. ⊕LE wound NWB dsg CDI Neurovascular check intact DEB pt being able to wiggle toes. Strong pedal pulse and skin coloration cap refill WNL Will cont to monitor b(6)-2 [redacted]
1030.	Upon trying to crutch walk pt. c/o being dizzy. Sat up at bedside for 10 min pt collapsed and was assisted to the floor. from floor was assisted to chair VS taken BP 104/5[illegible] HR 107 - Resp 22 rapid and shallow O2 Sat 99% on RA FSBS obtained 130. Neurovascular check remains intact. Will notify MD. b(6)-2 [redacted]
14DEC03	(0000) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. ⊕ c/o pain. Pt ↑ in chair until 2300. Amb

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(6)-2

14DEC03 (0245) to ~~PC~~ KAS bed c̄ walker s̄ difficulty. Dsg to RLE Δd c̄ Kerlix wrap. Small amount of sero-sang drainage noted. SL in @ hand dlcd d/t infiltration 18g IV started in @ forearm s̄ SISX infiltration. Tol. reg. diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ SISX complications. Will continue to monitor. b(6)-2 [redacted]

14 Dec 03 0700 - Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort. Lungs clear HRRR Active BS x4 quads ornately spontaneously s̄ difficulty @ leg wound NWB crutch walk training OOB to chair elevate. Wound dsg CDI minimal sero-sang ~~drge~~ drainage to dressing IV AB+ tx. Afebrile. Will cont to monitor b(6)-2 [redacted] assume

14 DEC 03 Assumed care @ 1815 pt A+O x3, LNS pt hs Ø c/o pain @ this time, pt @ leg elevated, dsg to @ leg Δ'd with ace, some sero-sang drainage from upper @ thigh, restraints x2 in place will monitor [redacted]

(0330) Concur c̄ above assessment. [redacted]

b(6)-2

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, print: 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 50
(Prescribed by TSG/HCMR 4 MAR 1983)

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Dec 03	0720- Assumed care of pt. A+O x 3. Sleep easily arousable lungs CTA HRRR Active BS x 4 quads. Urinating spontaneously w/ difficulty. Tolerates PO well. @ LE wound dsg CDI serosang drainage to prior dsg Neurovascular check remains intact AEB distal pedal pulse +1 cap refill and skin tone WNL pt able to wiggle toes. Labs from 14 Dec on chart. Will cont to monitor — b(6)-2 [redacted] nurse.
15 DEC 03	Assumed care @ 1815 pt A+O x 3, WN, pt has 0 c/o pain at this time @ thigh wrap exhibiting some serosang drainage from upper area, dsg replaced (dry) with clean, right lower extremity elevated, restraints x2 in place. pt given Ambien 2200 for sleep. Will Monitor — b(6)-2 [redacted]
16	(0130) I concur c̄ above assessment. — [redacted]
16 Dec 03 1000	Assumed care of pt. @ 0600 resting in bed easily awaken A+O x 3. VSS Denies having pain or discomfort at time. Lungs clear HRRR Active BS x 4 quads Urinates spontaneously w/ difficulty @ LE DSG CDI Minimal serous drainage Neuro check intact. Will cont to monitor b(6)-2 [redacted] nurse
16 Dec 03	Assumed care 1800 hrs. VSS, A+O. Drsg to @ LE CDI. LS CTA (B), (D) BS x 4 quads. Pain controlled c̄ percocet. Voids Spontaneously c̄ difficulty. OOBT Bedside comode. BM x 1. Drsg Δ'd @ 2200. Will cont to monitor. — [redacted] Spc 91WM6 b(6)-2 [redacted]

STANDARD FORM 505 (REV. 5/1999) E.O. 12958 USAPA

[redacted] b(6)-4

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 DEC	Neurology
1615	32 y/o RAD Iraqi EPW with hx of "hypotension" x 2 years (actually most consistent with migraine HA's → described as severe HA's, dizziness (vision Δ's, nausea, photophobia occurring 1-3x/month lasting for ≈6 hours), kidney stones and (c) thigh injury (? MVA ~ 1987) who presented to 28th CSH one month ago with (R) femur/tibial plateau fracture. Since admission neurological concerns were raised regarding patient's inability to ambulate and "collapsing" whenever upright (per nursing) for the past 1-2 weeks. Patient denies any associated HA, nausea, vision changes or other symptoms associated with spells. He says they only happen when he stands up. Nurses describe patient starting off and of collapsing into their arms with ↓ responsiveness for seconds to minutes. He has had incontinence x ~ both most recent spell. No apparent seizure like activity. He denies any current vertigo/dizziness. Per nursing he has not been eating much. VS: BP 100/60's HR 100 afebrile. Neurological Exa: alert, oriented, follows simple commands, speech fluent (through interpreter), VFSTC, EOMI ~ few beats of vertical gaze nystagmus, fundi ⊘, pupils 3mm → 2mm bilat, face symmetric, motor 5/5 x (R) proximal LE not tested 2° to pain, some mild weakness 4/5 of proximal LLE (? give way), DTR's 2+/4 and symmetric, coordination & F to N normal ~ ataxia Imp: (1) Syncope - likely orthostatic hypotension, possible etiologies would include dehydration/poor PO intake (malnutrition) with related medical/surgical issues. Unlikely to be seizure manifestation, vestibular dysfunction or central nervous system disorder.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

(3) Hx of migraine HA's (none currently)
(3) (R) femur/tibial fx s/p surgery

Rec (1) ✓ orthostatic BP's + sitting/lying/standing with HR
(2) consider ↑ing calories (or encourage PO intake) or IV fluids if found to be orthostatic
(3) would add MVI i qD to diet
(4) no need for further neurological testing at this time
(if spell continues would consider cardiac eval (incl. cardiac monitoring)

[redacted]

b/w

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

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 56
Prescribed by SOAMDMR AFMR 4100.51

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12/14/03 1222	155. AO. ⊕ pulse to RLE. PSG's d'd. stated severe, yellow drainage to all dressing d'd clothing appropriately & placed in chair. CVS intact to RLE. ROM. LS CTAB. BS ⊕ x4. c/o foley tied and encouraged to walk as much as possible. Pt understood through interpreter. ∅ s/s skin breakdown or infection to wound. [redacted] b(6)-2
17 DEC 03	Assumed care 1815 pt awake + oriented x3, WD pt has ∅ c/o pain at this time, dsg to right upper thigh exhibiting minimal serosang drainage, dsg d'd with curlex CDI, restraints x 2 in place, ⊖ skin breakdown. Will monitor [redacted] b(6)-2
18	(0225) I concur c above assessment. [redacted]
12/18/03 1330	155. AO. PSG d'd to RLE. Moderate amount of serous drainage to dressing prior. Resting comfortably in bed. Encouraged to walk and pt. understood. [redacted] b(6)-2 to ⊕ fever. Verify sportscrew, light ankle wire. Provided IS and performed med q 2-3°. ∅ s/s infection to wound or s/s to skin breakdown. [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18Dec03	2150- assumed care of pt @ 1800. VSS-AO pt. has ∅ c/o pain or discomfort. completed Dsg Δ. (+) sero-sang drainage. Light Brown. JP SL to (R) ant. CDT @ S/Sx inf. (R) leg elevated. (+) edema. Pt. voiding c/o Diaurnal. Pt. resting in bed @ this [redacted] time. Will cont. to monitor. [redacted] Concur c̄ above. [redacted]
19Dec03 1000	VSS. AO. Mild c/o stomach pain and provided 30cc Maalox and stated feels better. T@ 99.4 and provided 8 percent for accompanied pain. (R) pulse to RLE. DSG intact to RLE and reinforced c̄ Kerlix roll. Ecchymotic, dark brown drainage to DSG moderate amount and Δ'd PRN. ∅ S/S infection [redacted] skin breakdown @ this time. [redacted]
1030	Δ'd DSG to (R) upper torso CT site. Wound site is pink, minimal drainage ∅ S/S infection [redacted]
19Dec03	(2250) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Pt OOBTC, ambulated c̄ crutches s̄ difficulty. Dsg to (R) thigh Δd c̄ Kerlix roll. Small amount of sero-sang drainage noted. SL in (R) forearm d/cd d/t infiltration - catheter intact. 18g IV started in (R) upper arm, flushes well s̄ S/Sx infiltration. Tol. reg diet well. voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted]

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NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 DEC 03 1700	VSS. A&O OOB > Amb hallway X2 and tolerated well. Ø c/o dizziness. (R) LE Saline lock patent & intact. Peripheral pulses palpable (R) posterior thigh wound unchanged from yesterday. Dry dry applied as ordered. Large opsite dressing to (R) LE intact. Consumed 30-50% of meals. Consuming ⅔ of water P.O. Ø c/o pain throughout shift. In bed ⊼ 2 point restraints in place without compromising circulation or skin integrity. Will continue care as planned b(6)-2 [redacted] CTA/RN
22 DEC 03	(0015) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Dsg to RLE Cd c̄ Kerlix roll. Op site dsg leaking sm. amount of sero-sang drainage. SL in @ upper extremety flushes well s̄ S/Sx infection/infiltration. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]
22 DEC 03 1200	Pt c/o, VSS, Ø c/o pain, drsg to (R) LE ā/d. Large opsite drsg intact (R) LE. HL intact (R) AC. Consuming meals & fluids. s̄ difficulty. Levaquin IV cont per orders. Plan: pain ctrl, amb c̄ crutches. Will monitor b(6)-2 [redacted] RLUM6
23 Dec 03	(0845) VSS. c/o pain. Med ō 2 pec. Pt OOB to BSC. Sm. BM x1. Pt back in Bed. BS CTA, BS + 4 quads. Voids clear, yellow. ~~Et~~ Clear dsg to (R) leg. Ø signs of infection or leakage. Tol b(6)-2 Powell. Will Monitor. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

20 DEC 03 VSS Alert & Oriented. Pt changed dsg
1130 to (R) thigh using proper technique. Wound
to posterior (R) thigh 2.5cm x <0.3cm. Tissue
pink & moist. Consumed 10% of Breakfast.
OOB to chair x 1 hour and ambulated
c̄ crutches down hallway. Pain
Ø c/o dizziness. Voided. Opsite dsg intact
to RLE. (R) Upper arm saline lock patent &
intact. 2 point restraints in place without
compromising circulation or skin integrity.
Will continue plan of care. b(6)-2 [redacted] DWM

21DEC03 (0125) Assumed care @ 1800. Pt alert, speaking Arabic
VSS. Ø c/o pain. Sleeping well c̄ aid of Ambien.
Pt OOBTC. Amb well c̄ crutches. Dsg to RLE
reinforced c̄ Kerlix wrap. Small amount of sero-
sang drainage noted from dsg. Tol. reg diet well.
Voiding s̄ difficulty. SL in (R) upper arm flushes
well s̄ s/sx infection/infiltration. 2-point
restraints in place s̄ s/sx complications. Will
cont. to monitor. b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

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PROGRESS NOTES
Medical Record

STANDARD FORM 51
Prescribed by SGA/DCMR (AFIS 168)

[redacted]
b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 DEC 1310	Rt alo, VSS, ∅ clo pain. LCTAB, ⊕BSx4, drsg to ⓡLE CDI small amt bloody drainage noted. ⊕1 edema to ⓡ FOOT. ⊕ pulses, warm to touch. Rt slipped in BR today. p̄ spraying water everywhere. ∅ further injury noted, ∅ clo pain expressed, VSS p̄ fall. MD on call aware. Rt back un bed after fall ⓡ leg elevated. 2 pt restraints on while un bed s̄ complications. Will monitor [redacted] LA
23DEC03	(2315) VSS. ∅ c/o pain. Δ'ed DSG to ⓡ leg. Dry DSG. sutures intact. 2" x 1" wound. Sm. amt of serosang drainage from site. ⊕1 edema to ⓡ foot, ⊕2 pedal pulse. BS CTA, ⊕BS x 4. Voids clear, yellow s̄ difficulty. Tol po well. Will monitor [redacted] TI
24 DEC 03 @ 1050	Rt alo, VSS, ∅ clo pain @ this time. Drsg Δ'd ⓡ leg. small amt sero-sang drainage noted. sutures intact. edema to ⓡ foot ↓. ⊕2 pedal pulse, warm to touch, ambulated to BR c̄ crutches. IV Levaquin con't per orders. 2 pt restraints on s̄ complications. Will monitor [redacted] Alum
24 DEC 03 @ 2315	Assumed care of pt. @ 1800. VSS. A&O. Pt. given ⅋ Percocet for c/o pain to ⓡLE. Pt. observed while performing own

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

DEPART. SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

b(6)-4

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PROGRESS NOTES
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DATE NOTES

(cont.) DSG Δ to (R) LE, sutures intact, mod. serous drainage to old DSG. Pt. encouraged to straighten (R) LE in bed as much as possible. Pt. verbalized understanding. Voids CYU ∓ difficulty. ⊕ BS all 4 quads. Pt. reports pain to inside of mouth ∓ eating food that was too hot. Pt. reported eating a small amount of dinner as a result of pain. Pt. drinking H_2O ∓ difficulty. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL. Pt. asleep @ this time. Will cont. to monitor, [redacted] 2LT, AN

b(6)-2

Ø930 Assumed care of pt. pt A+Ox3, VSS, LS CTA
25Dec.03 (B), ⊕BSx4, ø c/o pain. (R) LE dsg Δ'd, mode-
Ø930 rate amount of serosang drainage on
dd dsg, sutures to wound CDI, wound
appears moist + pink ∓ S/Sx of infex,
encouraged to extend (R) LE as much as po-
ssible, cont to complain about pain in mou-
th, consumed 30% of diet, started IV
on (L) AC, flushes well, ø S/Sx of skin bre-
akdown, voiding CYU ∓ difficulties [redacted] 2LT, AN

b(6)-2

26DEC03 0345 Assumed care of pt. @ 1800. VSS. Pt. sleeping @ [redacted] Pt. awoke
for c/o pain to (R) LE. Dry DSG Δ to (R) LE, mod. serous drainage,
sutures intact, Ø S/Sx of infex. IVSL to (L) AC, flushes well.
Voids CYU ∓ difficulty. Pt. NPO for SX today. Pt. in 2 point
restraints, Ø signs of skin breakdown. All other assessments WNL.
Will cont. to monitor. [redacted] 2LT, AN

b(6)-2

STANDARD FORM 509 (REV. 1-1999) B

[redacted]

b(6)-4

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
26 DEC 0950:	Pt A10, VSS, Ø c/o pain, LCTAB, ⊕BSx4, ⊕ L thigh drsg Δ'd, wound pink, sutures intact, Ø drainage noted. ⊕ pulses, good passive ROM. amb c̄ crutches x 1 to BR. IV Levaquin con't per orders. NPO for OR today. 2 pt restraints on s̄ complication. Will monitor [redacted] LPN.
1700	Pt to OR via stretcher (b(6)-2 [redacted] LPN.
26DECØ3 (2250)	Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt returned from PACU via gurney in stable cond. Tx to bed s̄ difficulty. Dsg to RLE CDI. JP to RLE draining small amount of sero-sang drainage. Pt able to move toes. ⊕ pedal pulse equal bilat. Tol. reg. dinner. IVFs SLd in IV in ⊙ arm. Awaiting POV. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. b(6)-2 [redacted]
(ØØ1Ø)	2ØØcc sero-sang drainage from JP in RLE. Report given to oncoming shift. b(6)-2 [redacted]
27DECØ3 @1015	Assumed care of pt @ 0100. VSS. No c/o pain this A.M. RLE dsg CDI, JP c̄ serosanguinous drainage noted, ⊕ CMS to RLE, +2 DP pulse, equal BIL. LS CTA ⊕ BS, tol reg diet, void s̄ difficulties (CONT) [redacted]

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

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PATIENT'S IDENTIFICATION (Patient's name, grade, rank, unit, hospital, date of birth, sex, blood type, Fleet Number) | REGISTER NO. | WARD NO.

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[redacted] b(6)-4

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1045 (cont) Pt ↑ amb c̄ P.T. s̄ difficulty. 2pt restraints m s̄ S/Sx of skin/circulation compromise. Plan: enc amb, encpo, monitor JP output, pain control. [redacted]

@1800. JP drain = 15cc sero sanguinous drainage. [redacted]

28DEC03 (0004) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Dsg to RLE CDI. JP to @ leg draining small amount sero-sang drainage. Pt OOBTC. Amb well c̄ crutches. SL in @ ac flushes well s̄ S/Sx infection/infiltration. 2-point restraints in place s̄ S/Sx complications. Tol. reg diet well. Voiding s̄ difficulty. Will continue to monitor. [redacted]

(0005) JP drained 10cc sero-sang drainage this shift. Report given to oncoming shift. [redacted]

28DEC03 0945 assumed care of pt @ 0600. VSS. 0% pain. LS CTA, ⊕BS, tol reg diet void s̄ difficulty. RLE dsg c̄ ace wrap, CDI, edema noted, ⊕2DP pulse, equal BIL c̄ ⊕ CMS. JP c̄ sero sanguinous drainage noted. Pt ↑ Amb c̄ crutches s̄ difficulty. 2pt restraints m s̄ S/Sx of skin or circulation compromise. Plan: cont enc OOB, enc po, monitor neurovasc status for RLE. [redacted]

28DEC03 1130 MD to BS for dsg Δ. Wound c̄ minimal drainage, sutures intact, JP intact. Dry dsg c̄ Kerlix fluffs & roll, ace wrap. Will monitor. [redacted]

28DEC03 (@1800) JP output = 10cc this shift. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12-26-03	OP Note
	PreOpDx: Infected (R) knee ∓ fx LTP, Distal femur
	PostOpDx: Same
	Procedure: I+D, removal of ABX beads, recon LTP c̄ methylmethacrylate
	Surgeon: [redacted]
	EBL: 50cc
	Fluids: 700cc
	Findings: 1/3 LTP missing, void filled c̄ ABX impregnated cement
	Drains: JP x1
	Cx: ∅ D(W) - 2 A11
	[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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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29DEC03	(0120) Assumed care @ 1800. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOBTC. Amb well c̄ crutches. Dsg to RLE CDI. JP draining small quantity sero-sang drainage. ⊕ foot swollen. ⊕ pedal pulse. Tol. reg diet well. Voiding s̄ difficulty. SL in ⊖ ac flushes well s̄ S/Sx infection/infiltration. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]
29 Dec 03 1100	Rec'd report and assumed care of pt. ⊖ c/o resp distress, pain or discomfort @ present time. Dsg Δ minimal drainage around sutures. distal pulse present. J.P drain serous fluid. Lungs CTA. BS(+). H/L flushed area relapsed. ⊖ skin breakdown under restraints. Tol reg diet. Will continue to monitor. b(6)-2 [redacted] 91WM6
1500	Pt given 650 mg of Tylenol for mild pain. b(6) [redacted] 91WM6
30 Dec03	(0140) VSS. c/o pain. Med c̄ 2 perc. Pt moved rooms 2° ⊕ MRSA. Amb on crutches c̄ steady gait. DSG to ⊕ knee CDI. Voids clear, yellow s̄ difficulty. Tol PO well. ⊕ ft b(6)-2 trace edema c̄ ⊕ 2 pedal pulse. Will monitor. [redacted]

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

DATE	NOTES
30Dec03 1100	Pt AtOx3, VSS, AtOx3, LS CTA (B), (+) BSx4, MRSA precautions, ∅ c/o pain, dsg (R) LE Δ'd, sutures to incision CDI, wound on knee ∃ s/sx of infex, moderate amount serosang drainage, CVU per urinal ∃ complications, IV HL FA intact, ∅ s/sx of infex, consumed 50% of breakfast, ∅ s/sx of skin breakdown, (R) LE elevated ∃ blanket, salt @ bed side. b(6)-2 [redacted] 9IW
1105	pedal pulses present, cap ref <3sec, able to move toes + feet [redacted] 9IW b(6)-2 [redacted]
11Dec03 0415	Assumed care @1800; VSS, pt A&O speaking [redacted], ∅ c/o pain, ambien for insomnia; MRSA precautions taken, Dsg to RLE CDI, ⊖drainage, pt OOB to BR, amb ∃ crutch assistance ∃ difficulty; pt voiding ∃ difficulty, Tol Regimen; S/L patent, flushing ∃ difficulty; (+)CMS, +2/3 brisk cap Ref to affected extremity, Restraints in place [redacted] to skin/circ, cont to monitor. b(6)-2 [redacted]
31Dec03 0930	Pt AtOx3, VSS, LS CTA (B), (+) BSx4, ∅ c/o pain, OOB → ambulate ∃ crutches, tol well, dsg (R) LE Δ'd, sutures to incision intact, wound draining mod amount serosang drainage, ∅ odor, ∅ s/sx of infex, IV SL (R) wrist patent, flushes well, ∅ s/sx of infex, voiding CVU per urinal ∃ difficulties, (+) pedal pulses, cap ref < 3sec, tol reg diet well ∅ s/sx of skin breakdown. [redacted] 9IW

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

31Dec03@2345 Assumed care @ 1800, USS, pt A&O speaking arabic, pain controlled c̄ percocet, pt OOB → shower, Tol well, dsg to RLE Δ^d, mod sero-sang. drainage noted; ⊕ CMS, +2PP, brisk cap Ref; pt voiding s̄ difficulty, tol PO well, ~~S/L~~ MRSA precautions taken, Restraints in place s̄ compromise to skin/circ, cont to monitor b(6)-2 [redacted]

1Jan04@0300 S/L D/Cd per pt; New one started in (R) FA, easily flushes s̄ s/s infection/infiltration b(6)-2 [redacted]

1 JAN 03@0730 - Assumed care of pt. A&O x3. USS sitting up in bed eating breakfast. Denies having pain or discomfort @ this time. Lungs clear HRRR Active BS x4 quads. Urinating spontaneously s̄ diff. Wound to @ LE sutures intact approximated at the thigh open wound c̄ serous drainage @ the knee dsg change complete this morning Isolation for MRSA precautions Afebrile Will cont to monitor b(6)-2 [redacted]

1 JAN 04 Assumed care @ 1800 pt A&O x3, USS pt HAS @ c/o pain at this time. MRSA precautions, isolation restraints x2 in place, ⊖ skin breakdown. Will continue b(6)-2 [redacted]

2 JAN 04 @ 0800 - Assumed care of pt. A&O x3. USS ⊕ c/o pain or discomfort at this time. Lungs clear HRRR Active BS x4 quads Urinates clear yellow urine s̄ diff

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 JAN 04 @ 0515	Assumed care @ 1800; VSS, pt A&O, pain controlled c̄ percs; dsg to RLE CDI, dsg reinforced c̄ Kerlix wrap; pt OOBTC X1 for 2°, tol well, ambs c̄ crutch assistance s̄ difficulty; pt tol Reg diet c̄ added salt; pt voiding s̄ difficulty; Restraints in place s̄ compromise to skin/circ; cont to monitor [redacted]
3 JAN @ 0800	Pt released to OR. [redacted]
3 JAN @ 1715	Assumed care of pt @ 0600. VSS. Pt arrived from PACU approx 1100 hrs via gurney, placed in bed c̄ 2 pt restraints in place. RLE in immobilizer, dsg CDI, Ⓟ CMS, Ⓟ 2 DP pulse, equal BIL. LS CTA, tol po well. Ⓡ subclavian CL flushes easily, position verified before transfer. Plan: incpo, encOOB, monitor output/intake. MN cont to monitor. [redacted]
	Assumed care @ 1800; VSS, pt A&O, pain controlled c̄ percs, pt OOBTC X1, tol well; dsg to RLE CDI c̄ immobilizer in place s̄ complications Ⓟ CMS, +2 PP, brisk cap Ref; pt voiding s̄ difficulty, tol Reg diet Ⓡ SC TL CL patent x3 easily flushing s̄ s/sx infection/infiltration Restraints in place s̄ compromise to skin/circ, cont to monitor. [redacted]
4 JAN 04 @ 0830	Falls assessment: Pt needs assistance in/out of bed; standby assistance when ambulating c̄ crutches 2° new RLE immobilizer. Will cont to assess. [redacted]
4 JAN 04 @ 1335	Assumed care @ 0600. VSS. A&O c/o pn, medicated per PN. Drsg: Reinforced beside knee of Ⓡ LE. immobilizer in place. CL dsg D'd, site patent, Θ s/sx of infex, yellowish fluid observed in mouth, Θ signs of skin compromise on restraints. Will monitor. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6-3-03	OpNote
	Pre Op Dx: Infected (R) Breast, wound dehiscence
	Post Op Dx: Same
	Procedure: Repeat I&D, fasciocutaneous flap
	Surgeon [redacted] b(6)-2
	EBL: min
	Fluids: 3000cc
	Cultures obtained
	Drains: Remove x1
	Cx: ∅
	[redacted]
	b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 Jan 04	(2150) VSS. C/O pain ∝1. Med ō 2 perc. DSG CDI. ē leg immobilizer in place. Pt Amb ē steady gait on crutches. TLC to (R) SC infusing ABX ō difficulty [redacted] b(6)-2 Tol PO well. Voids CYU (+) BM
5 Jan 04 @ 0550	Assumed care @ 2200; VSS, Ø c/o pain/discomfort; pt sleeping majority of shift, did not get OOB; dsg to (R) leg CDI ē immobilizer in place; pt tol Reg diet, voiding ō difficulty; CL patency, Restrain in place ē compromise to skin/circ, cont to monitor. [redacted]
5 JAN 04 @ 0800	Assumed care of pt. AOx3. VSS Denies pain or discomfort. Lungs clear. Hx active. BS x4 quads. Tolerating PO well. Voiding ō diff. Clear yellow urine. QS - IV ABX TX cont. Afebrile. Ambulates w/ ē crutches leg brace to RLE. Will cont to monitor. b(6)-2 [redacted]
5 JAN 04 @ 1815	Assumed care of pt @ 1400. No c/o pain. RLE neuro-vascular intact, (+) CMS. Dsg Δ'd by MD, immobilizer in place. Pt ↑ Amb ō difficulty. (R) subclavian CL flushes easily. LS CTA, (+) BS, tol Reg diet well, void ō difficulty. Plan: cont IV ABX as ordered, enc OOB, pain control. b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
06 JAN 04 @ 0215	Assumed care of pt. @ 2200, VSS, A&O, Ø C/O pain. ®LE elevated in bed, DSG CDI, immobilizer intact. LS CTA bilat. ⊕ BS all 4 quads. Voids C4U ⊼ difficulty. Cont. IV anti-bx. ~~HVSL flushes well~~ (ERROR) M.D. TLC to ® SC, flushes well. Pt. asleep @ this time. Pt. in 2-point restraints, Ø signs of skin breakdown. Will cont. to monitor. — b(6)-2 [redacted] ILT, AN
6 JAN 04 @	0200 - Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort. Lungs clear HRRR Active BS x4 quads Urinates spontaneously ⊼ diff. IV ABX x TX cont. Central line dsg: CDI Ø s/s of infection Afebrile Wound cultures results at bedside chart. Crutch walks yard ⊼ difficulty Will cont to monitor — b(6)-2 [redacted]
6 JAN 04 @ 1730	assumed care of pt @ 1700. VSS, no C/O. MD to BS for drsg Δ, serosanguinous drainage noted when MD pushed on incision line. Kerlix wrap & immobilizer in place. ⊕ CMS to RLE, +2 DP pulse noted. LS CTA, ⊕ BS, tol regular diet void ⊼ difficulty. ® subclavian CL flushes easily. 2pt restraints dry skin/circulation compromise. Plan: OOB Amb c crutches, CL drsg Δ, encpo, monitor pain. — b(6)-2 [redacted]

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DATE	NOTES
7JAN04 @ 0210	Assumed care of pt. @ 2200, VSS, Ø c/o pain. Ⓡ LE elevated in bed, immobilizer to Ⓡ LE, serous drainage to dsg at Ⓡ knee, CL to Ⓡ SC, TLC, one port occluded, CL dsg Δ'd c̄ sterile technique. Pt. tol. reg. diet well. Voids c̄ difficulty. Pt. on contact precautions. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. b(6)-2 [redacted] /LT, AN
7JAN03	2100 Assumed care of pt. @ 2000. VSS a+o, no c/o pain @ this time. Reinforced dsg to Ⓡ LE. immobilizer in place Ⓡ leg elevated. ⊕ pedal pulse. CL CDI Ø S/Sx infection. Pt. voids cyu via urinal spontaneously. Tolerates Regular diet well. Pt. ambulates via PT. Will cont. to monitor pt. [redacted] b(6)-2 Tamara with abn assessment AN
7JAN04 @ 1745	assumed care of pt @ 1800. no c/o pain. MD Δ'd dsg on rounds this p.m. Dsg CDI, immobilizer in place ⊕ CMS. NSGTA, ⊕ BS, tol reg diet well, void c̄ difficulty, pt ↑ AMB c̄ crutches c̄ difficulty. 2pt restraints on c̄ S/Sx of skin/circulation compromise. Plan: encc AMB, encc OOB, pain control, monitor dsg. b(6)-2 [redacted]
~~7jan04 @ 0540~~	~~Assumed care @ 2200; VSS, pt a+o, Ø c/o pain; pt sleeping majority of shift; immobilizer in place, dsg CDI, Ø drainage; pt tol Reg diet; voiding c̄ difficulty; Restraints in place c̄ compromise to skin/circ, cont to monitor~~ b(6)-2 [redacted]

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b(6)-2 All except where noted otherwise

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8 JAN 04 @	0630 - Assumed care of pt, AOX3. VSS Lungs clear NERR Active BS x4 quads. Tolerating PO well Voiding ↓ diff MRSA precautions IV ABX TX cont. Afebrile. Wet + dry to @LE Dressing CDI. RLE Brace to leg for immobilization Neuro check WNL Will cont to monitor [redacted]
8 JAN 04 @ 2100	assumed care @1400. VSS, No C/O pain. RLE immobilizer in place, dsg Δ2, serosanguinous drainage noted from incision line ↓ open wound. WTD dsg applied. @CMS to RLE, +2DP pulse, equal BIL. LSCTA, @BS, voids ↓ difficulty. 2pt restraints in place ↓ skin/circulation compromise. Plan: enc ODB, enc po, monitor NVstatus pain control PRN. [redacted]
9 JAN 04 @ 0435	Assumed care @2200; VSS, ø c/o pain, pt AO; immobilizer to (R) leg in place, dsg CDI, ø drainage; pt DOB to amb in hall c̄ crutch assistance pt sat in hallway for 1° - tol well; (A) ENS throughout; pt tol Reg diet, voiding ↓ difficulty, cont MRSA pt precautions; Restraints in place ↓ compromise to skin/circ; will cont to monitor [redacted]
9 JAN 04 @	0635 - Assumed care pt sleep easily arousable AOx3. VSS Denies pain or discomfort. Lungs clear HRRR Active BSx4 tolerating PO well. Voids ↓ diff. Crutch walks WNL @LE dsg CDI immobilizer applied will cont to monitor [redacted]

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DATE	NOTES
9Jan04 @1745	assumed care @1600. VSS, Ø c/o pain. MD to Δ drsg. minimal drainage noted. Immobilizer in place. ⊕CMS to RLE. Pt Amb ⊂ difficulty. ⊕subclavian CL flushes easily. 2pt restraints on while in bed. Plan: enc COB, enc po, monitor drainage [redacted]
09JAN04	(2355) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt COBTC @ Δ of shift. Amb ⊂ diff. c̄ crutches. Immobilizer in place on RLE. Dsg to RLE CDI. ⊕SC TL flushes well x3 ports ⊂ sisx infection/infiltration. voiding ⊂ difficulty. 2-point restraints in place ⊂ sisx complications. Will cont. to monitor. [redacted]
10JAN04 @	0630 – Assumed care of pt. A+Ox3. USC. Denies pain or discomfort. Immobilizer to RLE in place. Neuro check WNL. crutch walks ward without diff. Central line triple lumen Ø s/s of infec. Afebrile. All other assessment findings WNL. Will cont to monitor [redacted]
10JAN04 @ 1745	assumed care of pt @ 1400. VSS. No c/o pain. RLE drsg Δd by MD, MD reports wound is improving. ⊕CMS to RLE, ⊕2DP pulse. Pt ambulates well c̄ crutches. LS CTA, ⊕BS, tol regular diet well, good appetite noted. ⊕SC central line flushes easily. Voids ⊂ difficulty. 2pt restraints on ⊂ skin/circulation compromise. Plan: enc po, enc ambs, pain control prn. [redacted]
11JAN04	(0050) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. Ø c/o pain. Amb well c̄ crutches. RLE in immobilizer. Dsg CDI. ⊕SC TL flushes well ⊂ sisx infection/infiltration. Voiding

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12JAN04	(cont) difficulty. 2-point restreints in place ~ S/Sx complications. Will cont. to monitor [redacted]
12Jan04	0800- assumed care of pt. @0000. VSS-A+O. Ø c/o pain or discomfort @ this time. [redacted] LS CTA (B), BS x4, soft non-tender, normal sinus rhythem (+) pedal (+) radial pulses. Completed dsg Δ to (R) knee. WTD wrapped ~ Kerlex wound pink + moist ~ sutures in tact. Slightly able to bend knee. Immobilizer in place ~ (+) pedal pulse (+) circulation. Pt. able to move toes (+) cap refill. (R) CL intact Ø S/Sx infection increasing IV ABX. Pt. completed personal hygiene. Pt. in two pt. restraints @ this time. Will cont. to monitor pt. [redacted]
08US-	Pt. c/o itching to groin area + arms. Pt. applied [redacted] powder to areas. Will monitor for relief. [redacted] I [redacted] agree with above assessment [redacted]
12Jan04	(2030) VSS. c/o sm. amt of pain. Med ~ 2 perc. Pt OOB + amb on crutches ~ steady gait. Δ'ed DSG to (R) leg. WTD. Wound appears beefy red. Sutures in place + well approximated. Immobilizer worn. Will continue to monitor. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11JAN04	(cont) s difficulty. 2-point restraints in place s s/sx complications. will cont to monitor. [redacted]
11 Jan 04 0830	VSS. A&O. ~~Knee~~ [redacted] RLE b(6)-2 c immobilizer in place OOB c crutches to BR c steady slow gait. Pedal pulses +2 Bilaterally. (R) Triple lumen SC central line patent & intact. Lungs CTA Bilaterally. Abd soft round non-distended. BS(+) x4 quad (R) LE old dsg c mod amt of serosanguinous drainage. Open wounds to (R) LE c pink moist tissue present. Consumed 50% of Breakfast. 2pt restraints in place without compromising circ or skin integrity. Will continue planned care b(6)-2 [redacted]
11JAN04 @2000	assumed care @1400. VSS. Alert & c/o: (R) LE in immobilizer, dsg CDI, min drainage from wound. (+) CMS to RLE. LS CTA, (+) BS, tol reg diet, void s difficulty: ↑ amb c crutches s diff. 2pt restraints on s skin/circulation compromise. Plan: encpo, encOOB, monitor NV status. b(6)-2 [redacted] CMS
12JAN04	(0135) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Pt OOB to amb c crutches and ↑ to chair - tol. well. Immobilizer on RLE in place. Dsg CDI. (+) SCR fusions well s s/sx infection/infiltration. voiding s

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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13JAN'03	Assumed care @ 1200 12 Jan '04 pt AOX3, WS pt has ∅ c/o pain @ this time. immobilizer in place @ leg, restraints x2 in place @ circulation @ skin breakdown, will monitor [redacted] ILT, AN
13Jan04 0830	WSS AXO. (R) TL SC patent & intact. (R) LE & Knee Immobilizer in place. Pedal pulses +2 Bilaterally. Consumed 40% of Breakfast. Voids clear yellow urine. OOB to chair for AM Care. (R) LE ↑ on foot stool while up in chair. Lungs CTA. ABD soft non-distended. BS (+) x4 quad. 0% pain since 0 this time. Will continue care as planned [redacted]
13JAN04 @2020	Assumed care @ 1900. WSS. A&O - c/o pn, medicated ÷ percs [illegible] RN. CL on (R) SC patent. Reg. diet tol well. Voiding clear yellow urine ∅ difficulty. OOB → toilet, hallway. Amb well on own ∅ crutches, immobilizer in place on the (R) LE. Drsg on (R) leg Δ'd per MD. ∅ signs of skin compromise on restraints. Will monitor. [redacted] PFC9/WLO

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted]

b(6)-4

b(6)-2 All unless noted otherwise

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
'4JAN04 0140	Assumed care of pt. @ 2200. VSS. Ø C/O pain. Pt. OOB ambulates in hallway c crutches c difficulty for 30 minutes. Pt. back to bed, (R) LE elevated, immobilizer in place. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] LT, AN
14 Jan04 1430	Assumed care of Pt @ 0600 A+O. VSS (R) SC TL central line patent + intact. Consumed ≥50% of meal. Voiding clear yellow urine. Lungs CTA. ABD soft ~~flat~~ non-distended. (R) LE c ~~brace~~ immobilizer in place. (R) LE incision c sutures intact + edges well approximated. Anterior + posterior incision to (R) thigh c purple mint tissue present. Ambulate c crutches well. Ø C/O pain voiced or noted this shift. Will report to next shift [redacted]
14 JAN 04 @ 2120	Assumed care @ 1600. VSS f&O. CL on (R) SC patent. Amb well on own c immobilizer on (R) LE using crutches. OOB + hallway, toilet. Reg. diet tol well. Voiding [redacted] clear yellow urine c difficulty. Drsg Δ'd on (R) LE. Wound healing well c-med. Serosang drain in old drsg. Ø signs of skin compromise on restraints. Will monitor [redacted]
	Concur c above. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(6)-4

[redacted]

MEDCOM - 24171

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
15JAN04 0100	Assumed care of pt. @ 2200. Temp 100.5, ⅋ Procedes for C/O pain (R) LE & fever. Pt. asleep @ this time, (R) LE elevated in bed, ÷ immobilizer in place. LSCTA bilat, (+) BS x 4 quads, voids CYU ÷ difficulty. Pt. in 2-point restraints ÷ Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. b(4)-2 [redacted]
1000	Assumed care of pt. @ 0000. + Temp. 103.5 this am. 625mg tylenol given @ 0800. Icepacks applied to groin, armpits + neck. Temp now 103.0. CBC ÷ diff. ordered. Completed dsg Δ to (R) knee. WTD (-) S/Sx inf. healing well. Sutures intact - well approximated. (R) SC TL central line patent + intact. LS CTA (B), abd soft nontender, voids cyd via urinal, tolerates PO + Reg diet. Ambulates well on own. Ø c/o pain @ this time. Awaiting transfer to ICU #2. Will cont. to monitor pt + Temp b(4)-2 [redacted]

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

DEPARTMENT/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted]

b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/198
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1/19/04	Brief Op Note
	Pre Op Dx: open Wounds (R) knee
	Post Op Dx: SAME
	Procedure: STSG (R) knee
	Surgeon: [redacted] b(6)-2
	EBL: ∅
	Fluids: 450cc
	Complications ∅
	Post Op Plan: wound ✓ 5 Days [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

01 ✓ [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Jan 04	43 yo Iraqi male admitted 12 Nov 03 after running a checkpoint and being shot in (R) leg and buttocks. Found to have open (R) knee with lateral femoral condyle fracture and segmental bone loss of lateral tibial plateau, large buttock wound. Pt'd initially with sparing x 5 days multiple I+Ds. On 26 Nov underwent ORIF of comminuted femoral fx with plate and screws. Subsequently had tibial plateau reconstructed with bone cement, flap moved to cover draining wound. On 19 Dec 04 underwent STSG to (R) leg wounds. Currently on crutch ambulation. Plan: Bacitracin Ointment Q day to wounds. Percocet 1-2 P.O Q 4-6 hrs pain. Levofloxacin 250 mg P.O Q day. Dressing change in 5 days. STAPLES OUT

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

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

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 12, MONTH NOV, YR. 83 — TIME 0700

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

CURRENT MEDS. (tetanus immunization and other data)

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): IED POST OP

SEX: M AGE: 32

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 0700

VITAL SIGNS			
TIME	0700		
BP	132/74		
PULSE	81		
RESP.	16		
TEMP.	96.1 T		
WT. (Child)			

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

ORDERS	INITS.	TIME
IV KVO	[redacted]	
CBC, Hot 8	[redacted]	
T&S, UA	[redacted]	

ASSESSMENT/DIAGNOSIS

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY
- QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- EMERGENCY / TODAY
- 72 HOURS / ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

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

S/P IED. R2yo EPW was shot while moving chickens across the road. Pt went to 82 FST team & left c Ex fix to (R) femur + 5th digit of (R) hand amputation. B/L opa well-nourished

O: Transferred from 82nd FST.

Defer to Dr. Albertson exam

A: See transfer note,

P: Admit - Ortho

[redacted] b(6)-2

[redacted] WUE ON SF 507, IF NEEDED)

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

EPW [redacted]

b(6)-4

[redacted] DER AND ID STAMP

b(6)-2

INSTR[redacted] PATIEN[redacted] medications ordered, any limitations and follow-up plans

MAJ [redacted]

b(2)-2

EMERGENCY CARE AND TREATMENT
Medical Record Copy

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

MEDCOM 24175

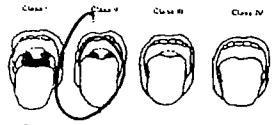
b(2)-2

[redacted]

Name FPW #2 SSN _____ Unit _____ Location _____

INITIAL ASSESSMENT

Airway
☒ Patent ☐ Nasal ☐ Oral
☐ Intubated ☐ Crich
☐ ETT #__ ☐ Trach



C-Spine
☐ CC ☐ BB ☐ Secured ☒ Clear

NORM MS. COMPETENT. Ø MS Δ's. GCS 15. Ø ML TENDER. Ø DISTRACTING. INJ's.

Breathing
☒ Spont Rate 32
Rhythm
☐ Reg ☒ Tachy ☐ Brady
☐ Sporad ☐ Even ☐ Abnl ___
Quality
☐ Reg ☐ Deep ☐ Labored
☒ Shall ☐ Sonorous ☐ Weak
☐ Assisted ☐ O_2 __ L/min
☐ Ambu ☐ Vent
BBS R ☒ CLR ☐ RLS ☐ WHZ ☐ ABS
L ☒ CLR ☐ RLS ☐ WHZ ☐ ABS

Circulation
☒ Spont ☐ CPR
Rhythm ☐ REG ☒ TACH ☐ BRDY
Pulse _____ ☐ Strong ☐ Weak ☐ Thread
B/P ☐ RAD >80 ☐ FEM >70 ☐ CTD >60
PASG ☐ Legs ☐ ABD ☐ Both
IV's #1 14 ga LR
#2__ ga_____
#3__ ga_____
☐ Tourniquet Where _____ When _____ What _____ Why _____
☐ Other _____

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☒ ABNL _____
☐ DIA ☐ PIN ☐ UNI ☐ FIX ☐ SLOW

MOI/DESCRIPTION
☐ Blunt ☐ Penetrating ☐ Burn
☐ Blast ☒ GSW ☐ Heat
☐ MVC ☐ Shrapnel ☐ Chem
☐ Fall ☐ Stabbed ☐ Elect
☐ Assault WITH _____ SEE 9's ↓
☐ Other _____ EST % _____

EQUIPMENT
☐ Weapon _____
☐ Sens Items _____
☐ Other _____

Vitals: HR 77 B/P 146/85 RR 24 POX 100 % TEMP _____ °F °C

DATE/TIME	NOTES
0005 12NOV03	LOWER (R) EXTREMITY WOUND
	UPPER (R) " "
	Ø gross blood on DRB
	APPROX 40 M c̄ MULT GSW TO RLE, PT A+O x3, NON ENGLISH
	SPEAKING. c/o PAIN TO RLE. PLAN OR FOR WASHOUT OF
	RLE. BBS CTA, VS STABLE, PAIN CTL'D c̄ [redacted]

b(6)-2

[redacted]

b(2)-2

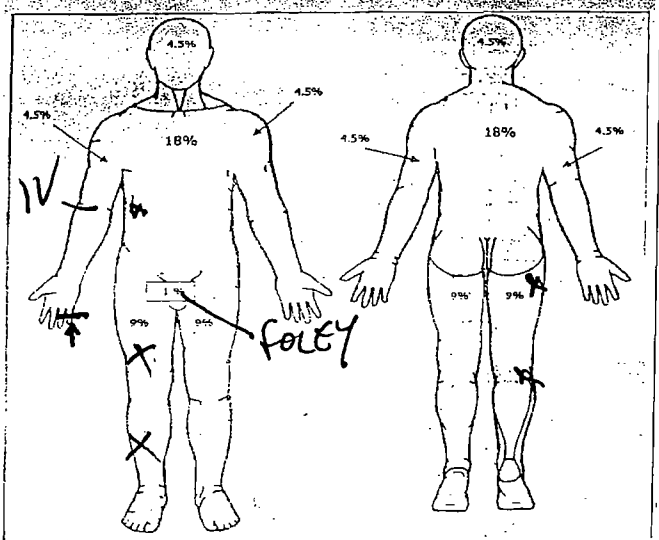
b(6)-4

[redacted]

Name EPW# [redacted] SSN _____ Unit _____ Location _____

Head-2-Toe/Burn Chart

INTERVENTIONS



Airway

☐ Suction ☐ Position ☐ Oral ☐ Nasal

☐ Intubated/Trach ☐ Crich By Whom _____

Breathing

☐ Assisted ☒ O_2 6 L/min ☐ Ambu ☐ Vent NRB

☐ Chest tube R #1 _____ #2 _____

L #1 _____ #2 _____

Time _____ By Whom _____

☐ Needle decomp R Time _____ L Time _____

Circulation Bag # and time

Fluid ☐ NS ☐ ____ 1L bags ☐1 ____ ☐2 ____ ☐3 ____

Blood ☐ PRBC ☐ Whole ☐1 ____ ☐2 ____ ☐3 ____

PASG ☐ Legs ☐ ABD ☐ Both

☒ Foley 0030 ☐ NGT _____

Other _____

ALLERGIES NKA

MEDICATIONS Ø

PREVIOUS HX _____

LAST MEAL _____

EVENTS (see MOI) _____

Description of Illness

_____

_____

_____

MEDICATIONS

TIME	MEDICATION	DOSE	RTE	BY
0005	MORPHINE	4mg	IVP	[redacted]
0007	ANCEF	1gm	IVP	[redacted]
0028	MORPHINE	3mg	IVP	[redacted]
0048	TETNUS	.05	IVP	[redacted]
0048	GENTAMYCIN		IVP	[redacted]
0048	PCN	2mu	IVP	[redacted]
0048	Morphine	3mg	IV	[redacted]
0058	MORPHINE	2mg	IVP	[redacted]

b(6)-2

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 12 NOV Diagnosis: Fx Femur / Tibia HD: POD:

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	Mobility	No limitations	4
	Slightly limited	3		Slightly limited	(3)
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	4	Nutrition	Excellent	4
	Occasionally moist	(3)		Adequate (Eats >50%)	(3)
	Moist	2		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	1
Activity	Walks frequently	4	Friction and Shear	No apparent problem	3
	Walks occasionally	3		Potential problems	(2)
	Chairfast	2		Problems	1
	Bedfast	(1)			

Add the total score Total Score 16

Above 20 — Low Risk
Between 16 and 20 — Medium Risk
Between 11 and 15 — High Risk
Below 10 — Very High Risk

Note: A Braden Scale Score of less than or equal to 15 indicates HIGH RISK –Requires immediate Ulcer prevention program.

Surgical wound (s): (Yes) No Location: (R) LE Size: _____ Drainage: _____
Tubes: _____ Appearance: _____
Dressing change: Not @ this time Reinforce only

Pressure Ulcer (s): Yes (No)
Stage I, II, III, IV (Circle the one that applies and describe below)

Location: _____ Size: _____
Wound character: Pint _____ Moist _____ Dry _____ Granulation tissue _____ Yellow slough _____
Odor _____ Purulent discharge _____ Eschar _____ Exudates _____

Type of dressing change: Wet-to-dry _____ Comfeel dressing _____ Carrasyn V-Gel _____ Alginate _____

Physician notified/consulted for wound debridement: Yes _____ No _____
CNS notified/consulted for Stage II and greater: Yes _____ No _____
Nutrition Referral: Yes _____ No _____
Physical Therapy Referral: Yes _____ No _____
Action Taken: _____ Date & Time: _____

REGISTER NO. | WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade: rank; hospital or medical facilithy)

PROGRESS NOTES

Medical Record
STANDARD FORM 509

[redacted] b(4) -4

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 12 Nov 03 15 Jan 04 Diagnosis: (R) femur fx (R) tib fx HD: 63 POD: See assessment sheet

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4	Mobility	No limitations	4
	Slightly limited	3		Slightly limited	3
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	4	Nutrition	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	1
Activity	Walks frequently	4	Friction and Shear	No apparent problem	3
	Walks occasionally	3		Potential problems	2
	Chairfast	2		Problems	1
	Bedfast	1			

Add the total score — *Total Score:* 19

Above 20 — Low Risk
Between 16 and 20 — Medium Risk
Between 11 and 15 — ~~High Risk~~
Below 10 — Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes Y No __ Location: R knee Size: 8cm long Drainage: minimal
Tubes: 0 Pins: 0 Appearance: CDI
Dressing change: q DAY

Burn wound (s): Yes __ No Y % BSA _____ Partial _____ Full _____
Location: _____ Size _____
Appearance: _____
Dressing change: _____

Pressure Ulcer (s): Yes ___ No Y
Stage I, II, III, IV (Circle the one that applies and describe below)
Location: _____ Size: _____
Wound character: Pink ___ Moist ___ Dry ___ Granulation tissue ___ Yellow slough ___ Tunneling ___
Undermining ___ Odor ___ Purulent discharge ___ Eschar ___ Exudates ___
Type of dressing change: Wet-to-dry ___ Comfeel dressing ___ Carrasyn-V Gel ___ Alginate ___

Physician notified/consulted for wound debridement: Yes ___ No ___ Date time MD notified _____
CNS notified/consulted for Stage II and greater: Yes ___ No ___
Nutrition Referral: Yes ___ No ___
Physical Therapy Referral: Yes ___ No ___
Action taken: _____ Date & Time 15 JAN 04 1730

REGISTER NO. | WARD NO. ICU2

Patient's Identification (For typed or written entries give: Name-last, first, middle; Grade; rank; hospital or medical facility;

PROGRESS NOTES
Medical Record
STANDARD FORM 509

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: | PATIENT ACUITY LEVEL : | POST-OP DAY: 1 2 3 4 5 6 7 8 9 10 11 12 | HOSPITAL DAY: 63

TRANSFER

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

Time 1100 To ICWD From ICWD ☐ AMBULATORY ☒ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time — Physician [redacted] Anesthesia (Specify): Ø

Procedure/Diagnosis (R) KNEE EXD 06-2 B/P ____ P ____ R 16 T 102.8

LOC A+O x 3 Neurovascular checks +

Dressing/cast REGIMMOBILIZER, WITH RLE Tubes (R) SUBCLAVIAN

Intake (IV, po) — Output (EBL, other) ____ Voided ☐ No ☒ Yes Amount: ____

Medication 650 TYLENOL PO

Other ____

Report From SIC [redacted] Received By SGT [redacted] 06-2

VITAL SIGNS

TIME:	1130	1930	0400	0600										
BP ARTERIAL LINE	85	94	78											
BP CUFF	44	57	53											
TEMPERATURE	102.8	100.2	104.2	101.5										
PULSE	116	124	124											
RESPIRATORY RATE	18	18	16											
OXYGEN (L/%)	—	—	—											
PULSE OXIMETER	96%	94%	97%											
O2 METHOD														

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

PAIN

TIME:	1100	1930	0400					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)		X	X					
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1100	1830
*Skin breakdown prevention	ED	[redacted]
*Falls prevention protocol		[redacted]
*Restraint protocol		NA
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: ____

TODAY'S WEIGHT: ____

WEIGHT CHANGE: ____

*Per hospital policy.

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

PATIENT IDENTIFICATION

C- [redacted]

b(6)-4

DIAGNOSIS: ____

DRG: ____ ADMISSION DATE: ____

LOS: ____ EXPECTED RELEASE: ____

CASE MANAGER: ____

PRIMARY CARE MANAGER: ____

ISOLATION REQUIRED (Specify): ____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 1300 INITIALS: [redacted]	TIME: 1830 INITIALS [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑ DLW-2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ORDER TORE D/T KNEE IMMOBILIZER ↑ c̄ CRUTCHES 5 PROBLEMS	☐ Knee immobilizer to ® LE ambulate crutches 5 assist	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ DRY GAUZE	☐ DSG to ® knee beneath immobilizer	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☐ See pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: ®SC / CL*	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: BLE TIME:	1300	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	0	0				
SENSATION	S	S				
MOTION	M	M				
PASSIVE FLEXION	0	/				
PERIPHERAL PULSE	2	2				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	1300	1830	
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: REG	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED: 30%	PERCENT CONSUMED: 25%
HOW TOLERATED:	HOW TOLERATED: WELL	HOW TOLERATED: well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT crutches

TEACHING

TIME: 1300 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: PAIN CONTROL, ADJUST CRUTCHES, CALL FOR ASSIST	CONTENT: b(6)-2 - Call for assist - Pain Management - Encourage PO intake	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 16Jan04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: ~~1/2/3/4/5/6/7/8/9/10/11/12/13~~ | HOSPITAL DAY: 24

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	2400	1212	2000	5460												
BP ARTERIAL LINE		93														
BP CUFF		49	112/76	94/56												
TEMPERATURE	100.5	100.7	97.8	99.7												
PULSE		103	96	89												
RESPIRATORY RATE		20	16	18												
OXYGEN (L/%)		✓														
PULSE OXIMETER		97%		96%												
O_2 METHOD		RA		RA												

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

PAIN

TIME:	2000							
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	N/A							

SPECIAL NEEDS

TIME:	2000		
*Skin breakdown prevention	N/A		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

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

PATIENT IDENTIFICATION

C[redacted]

b(6)-4

DIAGNOSIS: ~~amp 5th metacarpal~~ Open ® femur fx ® tib fx

DRG: _____ ADMISSION DATE: 12Nov03

LOS: _____ EXPECTED RELEASE: b(6)-2

CASE MANAGER: [redacted]

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: INITIALS:	TIME: 2000 INITIALS [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Imobilizer placed on (R) LE, Rom↓ (R) LE	☐ Imobilizer to RLE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dressing on (R) tibia + Femur FX C/D/I	☐ DSG RLE C/D/I DJ QD	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑ b/w - 2 A/V	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0730 INITIALS [redacted]	TIME: 2000 INITIALS [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided: flushed	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: * (R) Subclave / ok	IV Site #1: (R) SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: ~~Hep~~ Heplock	Comments: Proximal (+) flush Distal - heparin flush Medial (+) flush	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE	TIME: 0730	2100				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	0	0				
SENSATION	S	S				
MOTION	P	P				
PASSIVE FLEXION	D	D/P				
PERIPHERAL PULSE	3	3				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0730	2100	
ID band visible/legible	[redacted]		
Orient to environment prn	✓	✓	
Side rails (2/4) up	✓	✓	
Bed position low	✓	✓	
Call light within reach	✓	✓	
Review & post lab results	✓	✓	
Notify MD abnormal labs	✓	✓	
Incontinent urine/stool	✓	✓	
Linen change prn	✓	✓	
Turn/reposition q2h	✓	✓	
ROM q2h if immobile	✓	✓	
Antiembolic hose	✓	✓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 25%	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: well
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, ~~AMBULATE~~, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; c crutches; # TIMES/SHIFT	BEDREST, ~~AMBULATE~~, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; c crutches; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	TIME: 2100	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: (1) call for assist (2) Pain Control		CONTENT: • call for assist •		CONTENT:	
☐ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION

[redacted]

b(6)-4

INITIALS	SIGNATURE	SHIFT
ZCS	[redacted]	
KW	[redacted] SPC/Nurse	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0730	RLE	C/D/I in Immobilizer	[redacted]
				10(w)-2

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 17JAN04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 64/62/51/37/35/22/14 | HOSPITAL DAY: 65

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE																
BP CUFF	103/63	106/64	106/60													
TEMPERATURE	99.4	99.1	97.4													
PULSE	92	86	94													
RESPIRATORY RATE	24	20	18													
OXYGEN (L/%)																
PULSE OXIMETER	100%	99%	99%													
O_2 METHOD	RA	RA	RA													

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

PAIN

TIME:	0730	1830						
PAIN INTENSITY (10 / 5 / 0)	0	X						
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	Y	NA						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0730	1830	
*Skin breakdown prevention	NA	NA	
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ[redacted]

b(6)-4

DIAGNOSIS: Open (R) femur fx (R) tib fx an up 5th metacarpal

DRG: _____ ADMISSION DATE: 12 NOV 03

LOS: _____ EXPECTED RELEASE: b(6)-2

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

b(6)-2 A.11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0730 INITIALS: [redacted]	TIME: 1830 IN[redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ ROM To (R) LE 2° Fx. Immobilizer in place.	☐ Ø ROM to (R) LE 2° to Immobilizer in place for ⊕	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsg to (R) LE CDI	☐ Dsg to (R) LE CDI	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o pain 2/10 in (R) LE. Refuses pain medication @ this time.	☐ See pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 0730 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:			
IV site care provided:			
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(R) SC * / OK	(R) SC * / OK	
IV Site #2:			
Comments:		HL	

b(6)-3

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: BLE TIME:	0730	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION	M	U				
PASSIVE FLEXION	Ø	Ø				
PERIPHERAL PULSE	2P	2P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0730	1830		
ID band visible/legible	[redacted]			
Orient to environment prn				
Side rails (2/4) up				
Bed position low				
Call light within reach				

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 75%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: well
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, (AMBULATE), BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT: crutches	BEDREST, (AMBULATE), BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT: crutches	BEDREST, (AMBULATE), BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT: crutches

TEACHING

TIME: 0730 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Plan of care	CONTENT: - Call for assist - Pain management - Leg immobilizer	CONTENT:
☑ (Patient)/Family Verbalizes Understanding	☒ (Patient)/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

b6-2

PATIENT IDENTIFICATION	INITIALS	b(6) - SIGNATURE	SHIFT
CIN [redacted] b(6)-4	[redacted]	[redacted]	4 N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	(R) LE Lateral of (R) knee	Red; sutures intact.	WD dsg Δ

SECTION IV - NOTES

0730: Awake + alert. c/o pain 3/10 in (R) LE. Denies need for pain medication @ this time, will continue to monitor, [redacted] 15Jan04 0020 Central line flushed. Blue port flushing easily, and able to draw back blood. White port flushed easily, but unable to draw back blood. Brown port not flushing. Brown and white ports heparinized. 0010 pain or tenderness. Site & dsg CDI [redacted] CD/R

b(6)-2 All

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18Jan04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 03/04/05/06/07/08/09/10/11/12/13/14/15 | HOSPITAL DAY: 66

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	2300													
BP ARTERIAL LINE	✓															
BP CUFF	98/60	82/46														
TEMPERATURE	97.8	101.1	99.4													
PULSE	81	111														
RESPIRATORY RATE	14	16														
OXYGEN (L/%)	✓															
PULSE OXIMETER	97	97%														
O2 METHOD	NA	NA														
		2100														
	temp	101.8														

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

PAIN

TIME:	0730	2300						
PAIN INTENSITY (10 / 5 / 0)	4	10						
MED ADMINISTERED (Y/N)	Y	N						
RELIEF ACCEPTABLE (Y/N)	Y	NA						

SPECIAL NEEDS

TIME:	0730	2300	
*Skin breakdown prevention	✓	✓	
*Falls prevention protocol	✓	✓	
*Restraint protocol	✓	✓	
*Seizure precautions	✓	✓	
*Isolation precautions	✓	✓	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

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

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4

DIAGNOSIS: open (R) femur fx (R) tibfx, amp 5th metacarpal

DRG: _____ ADMISSION DATE: 12Nov03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): b(6)-2

b/c ✓ 2 A11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0730 INITIALS: [redacted]	TIME: 1500 INITI[redacted]	TIME: 2300 INIT[redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ⊘ROM TO RLE D/T IMMOBILIZER	☐ Immobilizer on RLE	☐ Immobilizer to (R) LE. UPC crutches
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ 8cm incision to (R) knee c̄ intact sutures c̄ gauze dsg CDI	☐ sutures CDI to RLE (knee)	☐ DSG Δ qd
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o PAIN 7/10 well controlled c̄ ⁿᵒ/₁₁ perfect	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEN[redacted] P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line[redacted]

	TIME: 0740 INITIALS: [redacted]	TIME: 1500 INITIA[redacted]	TIME: 2345 INITIA[redacted]
IV patency ✓ q 5 hr:		IV patency ✓ q hr:	patency ✓ q 8 hr:
IV site care provided:		IV site care provided:	IV site care provided: flush
IV tubing changed:		IV tubing changed:	IV tubing changed:
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	RSC / OK	IV Site #1: (R) SC / WNL	IV Site #1: (R) SC / OK
IV Site #2:		IV Site #2:	IV Site #2:
Comments: Flushed		Comments:	Comments: medial port ⊕flush ⊕blood return proximal ⊕flush distal ⊕flush

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE TIME:	0730	1500	2300			
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	1	1	1			
SENSATION	S	S	S			
MOTION	M	M	M			
PASSIVE FLEXION	~~0~~	0	0			
PERIPHERAL PULSE	3	3	3			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0730	1500	2300
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	✓		
Bed position low			
Call light within reach			

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE: REG
PERCENT CONSUMED: 90%	PERCENT CONSUMED: 80%	PERCENT CONSUMED: 50
HOW TOLERATED: WELL	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	~~☐ SELF~~ ☐ COMPLETE ☐ ASSIST ☐ TOTAL	~~☐ SELF~~ ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, ~~AMBULATE~~, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, ~~BSC~~, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0730 INITIALS: CB	TIME: 2300 INITIALS:	TIME: INITIALS:
CONTENT: PAIN CONTROL, ADLS, CALL FOR ASSIST	CONTENT: · Call for assist · Pain control	CONTENT:
☑ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
CIU [redacted] b(6)-4	[redacted]	b(6)-2 SGT, SIUMB	D
		[redacted] SPC/SIUMB	E
			N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	07 30	(R) KNEE	Ø ERYTHEMA OR EDEMA SUTURES INTACT	WTD DSG A

SECTION IV - NOTES

18JAN04 @ 2100: Pt had a temp of 101.8; up ~~apt~~ ,7 since 2000 VS. Was encouraged to ↑ PO intake as well as doing the incentive spirometer. PRN percocet given (per order) and attending physician was in surgery and unable to be notified; nursing supervisor given this info [redacted]

b(6) - 2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 19JAN04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 66/64/53/37/37/24/16 | HOSPITAL DAY: 67

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

Procedure Diagnosis _____ B.P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing cast _____ Tubes _____

Intake (IV, oral) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	400	1200	2000						
BP ARTERIAL LINE		101							
BP CUFF	82/44	60	94/48						
TEMPERATURE	102.9	98.8	99.8						
PULSE	121	98	100						
RESPIRATORY RATE	16	16	16						
OXYGEN L/M		—							
PULSE OXIMETER	94	99%	99%						
O2 METHOD	RA	RA	RA						

Oxygen Methods: NC = Nasal cannula; VM = Venturi mask; NM = Non-rebreather mask; FM = Face mask; M = Mask; T = Tracheostomy collar

PAIN

TIME:	0700	1200	2000
PAIN INTENSITY			
MED ADMINISTERED Y/N	N	X	N
RELIEF ACCEPTABLE Y/N	Y		NA

OTHER

TIME:			
FINGER STICK GLUCOSE			
INSULIN Y/N			

SPECIAL NEEDS

	0700		2000
			NA

24 HOUR TOTALS

PO | IV #1 | IV #2 | TOTAL IN | Urine | Stool | TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

open (R) femur fx (R) tibfib 12/20/03

b(6)-2 [redacted]

b(6)-2 A11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0700 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ø ROM TO RLE D/T KNEE IMMOBILIZER	☐ S/P surgery in knee immobilizer	☐ Ø ROM to RLE 2° to knee immobilizer Ambt Crutches
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ INCISION TO (R) KNEE STAPLES INTACT Ø S/S INFECTION, DSG CDI	☐	☐ DSG to (R) LE CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ PT DENIES	☐	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	☐	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0700 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q hr:	IV patency ✓ q 8 hr:
IV site care provided: FLUSH X3	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC # / OK	IV Site #1: (R) SC / WNL	IV Site #1: (R) SC CL / OK*
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments:	Comments: HL

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE TIME:	0700	1500	2300			
COLOR	P	P	P			
CAPILLARY REFILL	2	2	1			
TEMPERATURE	W	W	W			
EDEMA	Ø	Ø	Ø			
SENSATION	S	S	S			
MOTION	U	U	U			
PASSIVE FLEXION	Ø	Ø	Ø			
PERIPHERAL PULSE	3	3	2			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0700	1500	2300
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: 1	TYPE: NPO	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☐ ASSIST crutches; # TIMES/SHIFT

TEACHING

	0700-1500	1500-2300	2300-0700
TIME: 0700 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]	TIME: INITIALS:	
CONTENT: ↑ AD LIB, PAIN CONTROL, CALL FOR ASSIST	CONTENT: Call for assist, Pain management	CONTENT:	
☐ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	

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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 20 Jan 04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 66/63/53/39/37/24/16 | HOSPITAL DAY: 67

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	400	1130	2000
BP ARTERIAL LINE			
BP CUFF	103/82	104/62	96/48
TEMPERATURE	101.6	97.7	102.3
PULSE	109	106	120
RESPIRATORY RATE	16	16	16
OXYGEN (L/%)		—	
PULSE OXIMETER	99	97%	98%
O2 METHOD	RA	RA	RA

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

PAIN

TIME:	1130	1500	2315
PAIN INTENSITY (10 / 5 / 0)			
MED ADMINISTERED (Y/N)	Y	Y	Y
RELIEF ACCEPTABLE (Y/N)			N

OTHER

TIME:			
FINGER STICK GLUCOSE			
INSULIN (Y/N)			

SPECIAL NEEDS

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

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

b(6)-4

C [redacted]

DIAGNOSIS: amps 5th Metacarpal open (R) femur fx (R) tib fx

DRS: _____ ADMISSION DATE: 12 Nov 03

LOS: _____ EXPECTED RELEASE: _____

PAIN MANAGER: b(6)-2

PRIMARY [redacted]

MEDCOM - 24198

b(6)-2471

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 1137 INITIALS [redacted]	TIME: 1500 INITIALS [redacted]	TIME: 2315 INITIALS [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ ROM 2° knee immobilizer and injury to (R) knee	☐ ↓ ROM to (R) LE Due to Fx to Femur and tibia. Knee immobilizer in place. 5th finger amputation (R) Hand	☐ (R) ↓ ROM (R) LE 2° to splint and fx (immobilizer)
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ X TLC	☐ (R) Subclavian TLC white Port no blood	☐ X (R) LE
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ see pg 1	☑ Return	☑ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1137 INITIALS [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2315 INITIALS [redacted]
IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr: PRN	IV patency ✓ q ___ hr:
IV site care provided: Assessed	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC / OK	IV Site #1: (R) SC / OK	IV Site #1: (R) SC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: Blood return x8 ports. (+) flush x 3 ports	Comments: All ports flush no blood Return in white Port	Comments: Flushed x3 ports Blood return x2 ports

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) LE TIME:	1137		2310			
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	Ø	Ø	Ø			
SENSATION	S	S	S			
MOTION	M	M	M			
PASSIVE FLEXION	—	—	/			
PERIPHERAL PULSE	2D	2	2			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 1137		2310
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up	[redacted]		
Bed position low			
Call light within reach			

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs	[redacted]		
Incontinent urine/stool	[redacted]		
Linen change prn	[redacted]		
Turn/reposition q2h	[redacted]		
ROM q2h if immobile			
Antiembolic hose		6	

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Reg	TYPE:
PERCENT CONSUMED: Pt's family brings food	PERCENT CONSUMED: —	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1137 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2310 INITIALS: [redacted]
CONTENT: Medications, Pain management	CONTENT: - Plan of Care - no Δ Dsg till 24 Jan	CONTENT: explained - pain management - call for assist
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C b(6)-4 [redacted]	b(6)-2	[redacted]	00-14
		[redacted]	2
		[redacted]	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1500	(R) LE	covered c̄ gauze, ace wrap, & immobilizer	assessed
	2310	(R) LE	gauze wrap/ace wrap ODF c̄ immobilizer	assessed

SECTION IV - NOTES

1500 - No c/o of pain at this time. Pt Awake and Alert. Flushed TLC in (R) Subclavian 2 of 3 ports have blood return but all flush con't to monitor [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT 67/65/54/49/38/35/17

DATE: 21 Jan 04 | PATIENT ACUITY LEVEL: II | POST-OP DAY: | HOSPITAL DAY: 68

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Vomited ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	400	1200	2030	400
BP ARTERIAL LINE				
BP CUFF	87/41	149/80	165/57	107/61
TEMPERATURE	98.2	99.0	100	97.4
PULSE	70	97	98	73
RESPIRATORY RATE		16	16	14
OXYGEN (L/%)	99	—	—	
PULSE OXIMETER	94	99	100	99
O2 METHOD	RA	—	RA	RA

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

PAIN

TIME	2245	2400
PAIN INTENSITY (10 / 5 / 0)	X	X
MED ADMINISTERED (Y/N)	N	Y
RELIEF ACCEPTABLE (Y/N)		Y

OTHER

TIME:	
FINGER STICK GLUCOSE	
INSULIN (Y/N)	

SPECIAL NEEDS

TIME 06/1530

[redacted]

blw-2

[redacted]

YESTERDAY'S WEIGHT

TODAY'S WEIGHT

WEIGHT CHANGE

Other special needs

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

PATIENT IDENTIFICATION

C[redacted]

blw-4

open (R) femur fx, (R) tib/fib

ADMISSION DATE 12/00/03

blw-2

[redacted]

b(6)-2 A11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0615 INITIAL [redacted]	ME: 1530 INITIAL [redacted]	ME: 2400 INIT [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ROM 2° to knee immobilizer and (R) knee SIP surgery/injury	☐ ↓ROM (R) knee 2° immobilizer, ↓ROM (R) hip 2° femur fracture	☐ ↓ROM (R) LE 2° to immobilizer
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ (R) subclav. CDI	✓	☐ ↓ RLE
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓	✓	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0615 INITIALS [redacted]	TIME: 1538 INITIALS: [redacted]	TIME: 2400 INITIAL [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr: PRN	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC / CDI	IV Site #1: (R) SC / OK	IV Site #1: (R) SC / OK
IV Site #2: / patent	IV Site #2:	IV Site #2:
Comments:	Comments: HL	Comments: HL

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE TIME:	0615	1534	2400			
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	Ø	Ø	Ø			
SENSATION	S	S	S			
MOTION	M	Immobilized	M-tbs			
PASSIVE FLEXION	—	—	—			
PERIPHERAL PULSE	2+	2+	2P			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 0615	1530	2400	
ID band visible/legible	[redacted]			
Orient to environment pr				
Side rails (2/4) up				
Bed position low				
Call light within reach				

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Reg.
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

b(6)-2

TEACHING

TIME: INITIALS:	TIME: 1539 INITIALS [redacted]	TIME: 2400 INITIALS [redacted]
CONTENT: Pain mgmt	CONTENT: 1.) Pain management	CONTENT: explained - call for assist - pain management
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	b(6)-2	D
		LTAN	E
		[illegible]	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2400	RLE	ace wrap CDI & Knee immobilizer	Ø

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT 68/66/56/42/44

DATE: 22 Jan 04 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 26/18 | HOSPITAL DAY: 69

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

Procedure/Diagnosis _____ B.P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0000	400												
BP ARTERIAL LINE	105													
BP CUFF	62	100/56												
TEMPERATURE	99	97.2												
PULSE	79	90												
RESPIRATORY RATE	16	18												
OXYGEN (L/%)														
PULSE OXIMETER	100%	97												
O2 METHOD	RA	RA												

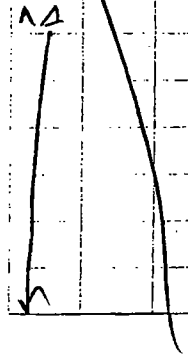
Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; BP = Bag/valve/mask; A = Ambient; TC = Trach collar

PAIN

TIME:	0830	2000	2310
PAIN INTENSITY (10 / 5 / 0)	X		
MED ADMINISTERED (Y/N)	Y #NOC	X	N
RELIEF ACCEPTABLE (Y/N)	Y		

SPECIAL NEEDS

TIME



YESTERDAY'S WEIGHT _____

TODAY'S WEIGHT _____

WEIGHT CHANGE _____

OTHER

TIME:				
FINGER STICK GLUCOSE				
INSULIN (Y/N)				

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

open (R) femur fx (R) tib/fib

ADMISSION DATE: 12 NOV 03

[redacted]

b(6)-2

b 1(a)-2 A11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0830 INITIALS: [redacted]	TIME: 2041 INITIALS: [redacted]	TIME: 2310 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ ↓ ROM RLE pain 5-10	☐ (R) Knee immobilized 2° femur fx.	☐ ↓ ROM RLE 2° knee immobilization
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ (R) Sub clavicle	☐ (R) SL IV.	☐ ⊼ RLE
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0835 INITIALS: [redacted]	TIME: 2042 INITIALS: [redacted]	TIME: 2310 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr: PRN	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided: assessed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC clear / COF	IV Site #1: (R) SL / OK	IV Site #1: (R) SC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments: SL

b(6)-2 All unless otherwise marked

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE TIME:	0830	2030	2310			
COLOR	P	P	P			
CAPILLARY REFILL	2	1	1			
TEMPERATURE	W	W	W			
EDEMA	Ø	Ø	Ø			
SENSATION	S	S	S			
MOTION	P	P	P			
PASSIVE FLEXION	P	/	/			
PERIPHERAL PULSE	P	2+	2P			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:		2030	2310
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Reg
PERCENT CONSUMED: 100%	PERCENT CONSUMED: 100%	PERCENT CONSUMED: 100%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, ~~AMBULATE~~, BSC, BRP, CHAIR	BEDREST, AMBULATE, ~~BSC~~, BRP, CHAIR	~~BEDREST~~, AMBULATE, BSC, BRP, CHAIR
	☒ SELF ☒ ASSIST	☐ SELF ☐ ASSIST	☒ SELF ☐ ASSIST
	# TIMES/SHIFT	# TIMES/SHIFT crutches	# TIMES/SHIFT

TEACHING

	0700	2030	2310
TIME:	0700	2030	2310
INITIALS	[redacted]	[redacted]	[redacted]
CONTENT:	Pain Control	1) Call for assist PRN	explained - pain management - call for assist
	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	[redacted]	m
		1 JAN	E
		2 JAN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	08	R LE	CDT	none
	2310	(R) LE	ace wrap c̄ immobilizer DDI	ø

SECTION IV - NOTES

22 JAN @ 1615 Pt Resting in Bed, no Complaints or questions @ this time. Pain well controlled c̄ meds. SP[redacted] RN/MC

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOW SHEET

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

SECTION I - PATIENT ASSESSMENT 69/61/56/43/41

DATE: 23 Jan 04	PATIENT ACUITY LEVEL :	POST-OP DAY: 27/19	HOSPITAL DAY: 70

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	2050	1020	0900											
BP ARTERIAL LINE		—														
BP CUFF	130/70	81/49	84/43	94/56	115/63											
TEMPERATURE	97.7	100.1	100.1	100.1	101.4											
PULSE	66	107	103	102	102											
RESPIRATORY RATE	14	14	16	16	15											
OXYGEN (L/%)	—	—	—													
PULSE OXIMETER	98	99	99	100	98											
O_2 METHOD	RA	[illegible]														

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

PAIN

TIME:	0900	1500	2000					
PAIN INTENSITY (10 / 5 / 0)	X							
		X	X					
MED ADMINISTERED (Y/N)	Y	N						
RELIEF ACCEPTABLE (Y/N)	Y	Y						

OTHER

TIME:	0900	1500	2300					
FINGER STICK GLUCOSE	N	N	N					
INSULIN (Y/N)	N	N	N					

SPECIAL NEEDS

TIME:	0900	1500	2300
*Skin breakdown prevention	[redacted]		
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			
b(6)-2			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

C[redacted]

b(6)-4

DIAGNOSIS: Open (R) Femur fx (R) tib/fib

DRG: —

ADMISSION DATE: 12 Nov 03

LOS: —

EXPECTED RELEASE: —

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): —

b(6)-2 A11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0900 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: [redacted] INITIALS: 2300
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	✓	✓	✓
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	✓ (R) Subclavicular line.	✓ (R) Subclav. line	✓ SKIN CHKD
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓ Pt c/o pain 8/10. Perc. given 0/10 post med.	✓ No c/o pain at the time.	✓ denies pain
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0900 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2800 INITIALS: [redacted]
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided: Cleaned area	IV site care provided: Cleaned site	IV site care provided: No access
IV tubing changed: N/A	IV tubing changed: N/A	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) Sub clav. * OK	IV Site #1: (R) Sub clav * OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

b(6)-2 All

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0800	1500	2300			
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	2	2	2			
SENSATION	S	S	S			
MOTION	M	M	M			
PASSIVE FLEXION	0	0	0			
PERIPHERAL PULSE	2	2	2			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0800	1500	2300
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results	N/A	N/A	I
Notify MD abnormal labs	N/A	N/A	I
Incontinent urine/stool	N/A	N/A	N/A
Linen change prn	[redacted]		
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose	N/A	N/A	N/A

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Reg
PERCENT CONSUMED: 70%	PERCENT CONSUMED: 30%	PERCENT CONSUMED: 70%
HOW TOLERATED: Well	HOW TOLERATED: Well	HOW TOLERATED: Well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR	BEDREST, AMBULATE, BSC, BRP, CHAIR	BEDREST, AMBULATE, BSC, BRP, CHAIR
	☒ SELF ☐ ASSIST	☐ SELF ☐ ASSIST	☐ SELF ☐ ASSIST
	# TIMES/SHIFT	# TIMES/SHIFT	# TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: 2300 INITIALS: [redacted]
CONTENT: Pain control	CONTENT: Pain control	CONTENT: pain control, monitor VS, PPP bilat
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	[redacted]	91WM6	Day
		91WM6	Day
		2LT/AN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

23 Jan 04 @ 2300 NM Note – 2000 VS = 81/49 BP, 100.1 temp, 103 pulse. Pt evaluated and asymptomatic. MD notified gave verbal order for NS bolus. Pt has no IV access. Pt refused IV access, Interpreter called explained to pt need for IV – pt continues to refuse. BPQ 2220 94/56 bp, 100.2 temp, 102 p. Pt encouraged to drink water, will pass to Am shift. [redacted]

b(4)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOW SHEET

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

SECTION I - PATIENT ASSESSMENT 70/68/57/44/42

DATE: 24 Jan 04 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 28/20 | HOSPITAL DAY: 71

TRANSFER

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

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0630	0730														
BP ARTERIAL LINE	/	/														
BP CUFF	/	/														
TEMPERATURE	100.1°	99.7														
PULSE																
RESPIRATORY RATE																
OXYGEN (L/%)																
PULSE OXIMETER																
O_2 METHOD																

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

PAIN

TIME:	0755							
PAIN INTENSITY (10 / 5 / 0)	X							
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	N							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0755		
*Skin breakdown prevention	[redacted]	b6-2	
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

C [redacted]

b(6)-4

DIAGNOSIS: Open (R) femur fx tib/fib

DRC: _____ ADMISSION DATE: 12 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): b(6)-2

II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
1. **NEUROLOGICAL:** Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☐
2. **CARDIOVASCULAR:** Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. **PULMONARY:** Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. **G.I.:** Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. **G.U.:** Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. **MUSCULOSKELETAL:** Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ @ L immobilizer ambulating c̄ crutches.	☐	☐
7. **SKIN:** Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ UTA Due to: Dressing and immobilizer	☐	☐
8. **PAIN:** No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. **PSYCHOSOCIAL:** Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1: _____ _____	IV Site #1: _____ _____	IV Site #1: _____ _____
IV Site #2: _____ _____	IV Site #2: _____ _____	IV Site #2: _____ _____
Comments: no IV access	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

b(6)-2

NEUROVASCULAR

SITE: R foot	TIME: 0755					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	M					
PASSIVE FLEXION	NA					
PERIPHERAL PULSE	2.					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 0755		
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	~~BEDREST~~ AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0755 INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT: Plan of care	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

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

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

24 Jan 04 @ 0155 Pt stable abt & awake ϕ complaints and ambulating c̄ crutches S̄ prefloors — [redacted]

24 Jan 04 0910 Patient DC to home, ambulatory c̄ crutches VS stable, DC summary, orders, and instruction complete. Rx Levofloxacin, Percocet, Bactracin filled — [redacted]

b(6)-2 A11

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE 31 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) [X] NKDA [ ] PCN [ ] LATEX [ ] IODINE [ ] TAPE [ ] FOOD REACTION:
	3. PREVIOUS SURGERY [ ] NO [X] YES (type): Ex Fix Placement

4. PROPOSED SURGICAL PROCEDURE:
I+D of Wounds

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Open Fx's
Tobacco ? ppd X___vrs Body Piercing ✓ Diabetes (Y) (N) ROM ✓(R) leg (L) Hand ASA/Motrin W 72hrs (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: See chart

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	G Pt. verbalizes any specific anxiety. G Pt. Exhibits relaxed body posture.	O. Allow pt. to verbalize freely. O. Explain Or environment and answer questions regarding surgery. as possible 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 ___ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	✓ Pt. will be able to breath 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 intubatior 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 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 form pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name-last, first, middle; grade, data; hospital or medical facility)
#[redacted] b(6)-4
[redacted]
13 NOV 03 b(2)-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: ✓

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~~ injury ✓ 4) Safety Devices ✓ 5) Hypothermia	O. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. 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.I. ✓ Potential Impairment of Mobility due to: ✓ 1) Pain ✓ 2) Intra operative Hazzards ✓ 3) prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. To/form 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 difficultly. O pt. will be 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 towel. etc) for positioning.
F. Special Senses F.I. ✓ 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.	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. as possible 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. Ø b(6)-2	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. Ø	OTHER NURSING INTERVENTIONS OR continuation of above interventions. Ø

[redacted]TE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted]RN/AN 13 NOV03 DATE

[redacted] POSTOPERATIVE EVALUATION : SKIN INTEGRITY: Boyle Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y)(N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☒ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities BREATHING EASY: (Y)(N)

☐ Transferred to Litter With ~~roller due to spinal~~ draw sheet

12. PREOPERATIVE EVALUATION PREPARED BY 13. PREOPERATIVE EVALUATION PREPARED
(Signature and Title) [redacted]

DATE: 13 NOV 03 TIME: 0850 [redacted] 13NOV03 TIME: 1305

REVERS OF FORM 5179, JUN 91 USAPA V1.0

b(6)-2

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

PATIENT TRANSPORTED TO OPERATING ROOM
IA BY
DATE TIME PATIENT ARRIVED IN SUITE

2. PATIENT IDENTIFIED, [redacted] PROCEDURE
VERIFIED BY CPT, AN
4. PATIENT IN ROO[redacted]
TIME b(6)-2 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

OMMENTS:

6. NURSING PERSONNEL

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

POSITION AND POSITIONAL AIDS *(Specify)* Head to towel. Arms abd <90° to

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

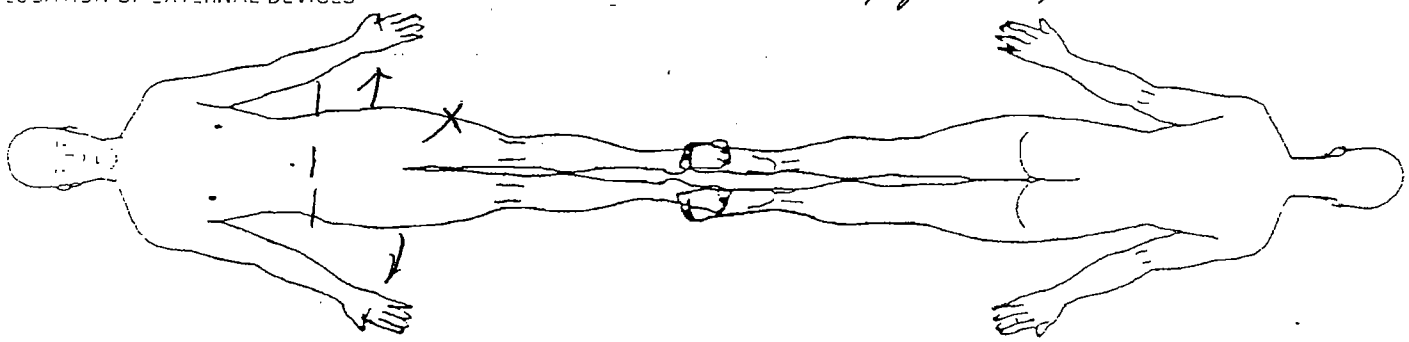
OMMENTS padded armboards, legs straight, heel padded. Position approved by Surgeon.

8. SKIN PREPARATION

AIR REMOVAL ☒ YES ☐ NO (L) leg
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (L) leg BY WHOM: CPT [redacted]
SITE: (R) hand BY WHOM: SSG [redacted]
COMMENTS: Approved / Approved b(6)-2

LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
[illegible]ge	☒ Yes	☐ No					
[illegible]dle Sharp	☒ Yes	☐ No		C	C	[redacted]	[redacted]
[illegible]strument	☐ Yes	☒ No					
[illegible]ther	☐ Yes	☐ No					

b(6)-2

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: B
GROUND PAD: BRAND 3M
LOT NO: 1494-1124

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMENS YES ☐ NO ☐	NAME	NAME
FROZEN SECTIONS YES ☐ NO ☐	NAME	NAME
CULTURE ON YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES DRAINS PACKING YES ☒ NO ☐

TYPE SIZE	1. 18Fr foley	2. 5/8" Penrose	3.
SITE	1. bladder	2. (R) knee	3.

18. DRESSING IMMOBILIZATION (Specify)

Xeroform
Kerlex
ACE

19. ADDITIONAL INFORMATION

WC II

Surgeon: Bal
Asst: Ward
Anes: Bella Iste

Bovie pad site
Clear postop

20. OPERATION(S) PERFORMED

I&D of (R) 5th digit. (R) hg Ex fix

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	0545	Litter

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

REVERSE OF DA FORM 5179-1, OCT 7

USAPA V1.0

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA ~~litter~~ gurney BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 13 NOV 03 TIME PATIENT ARRIVED IN SUITE 1153	4. PATIENT IN ROOM TIME 1153 NUMBER 1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 910 b(6)-2	RELIEF SCRUB	Ø
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	Ø

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt on padded O.R. Bed, Head on Foam Doughnut, Arms extended out to sides <90° in CAP secured to padded armboards c safety straps.

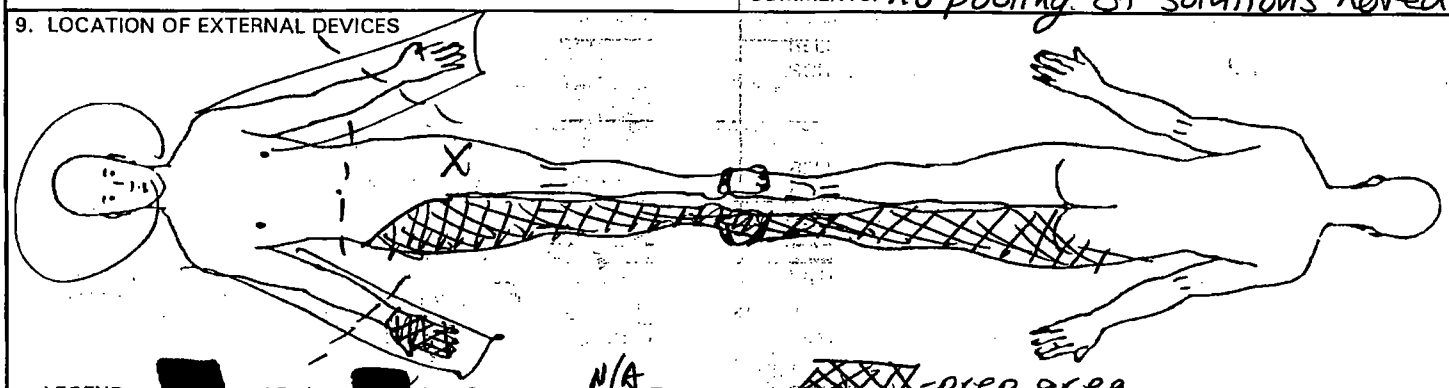
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: correct body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO	PREP SOLUTION *(Specify)* Beta/Beta
DONE BY: ☐ OR ☐ NURSING UNIT	SITE: RLE + (R) hand BY WHOM: CPT [redacted]
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP	SITE: BY WHOM:
COMMENTS:	COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND [redacted] ound Pad [redacted] afety Strap N/A Tourniquet X-prep area

C = Correct I = Incorrect

b(6)-2

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

[redacted]

13 NOV 03 b(2)-2

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

☒ ESU NO: R8E-105035

GROUND PAD: BRAND Valleylab Polyhesive II REM

LOT NO: 70337 / 2005-05

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

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-QS

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. 3/8" penrose	2.	3.
SITE	1. leg wound	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
moist Kerley Roll c NaCl
Kerley Fluffs, Kerley Roll,
ACE wrap.
(R)SF 2x2 plain sponges - 1" Conform gauze roll.

19. ADDITIONAL INFORMATION WC-TV
Surgeon: Dr [redacted] b(6)-2
Anesthesia: Gen/LMA-CPT [redacted] CRNA

DA5179 done

20. OPERATION(S) PERFORMED
I+D (R)LE wounds, Ex fix adjustment, (R)SF Dressing Δ

21. PATIENT TRANSFERRED TO PACU (ICU3) TIME ~~500~~ 1300 DA7389 METHOD Litter

22. [redacted] b(6)-2 CPT/AW

USAPA V1.00

MEDCOM - 24223

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Pt cart bed BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 15 NOV 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM TIME 0938 NUMBER 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ø

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: correct body alignment maintained, arms on padded armboards at less than 90°, bump under (R) hip, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

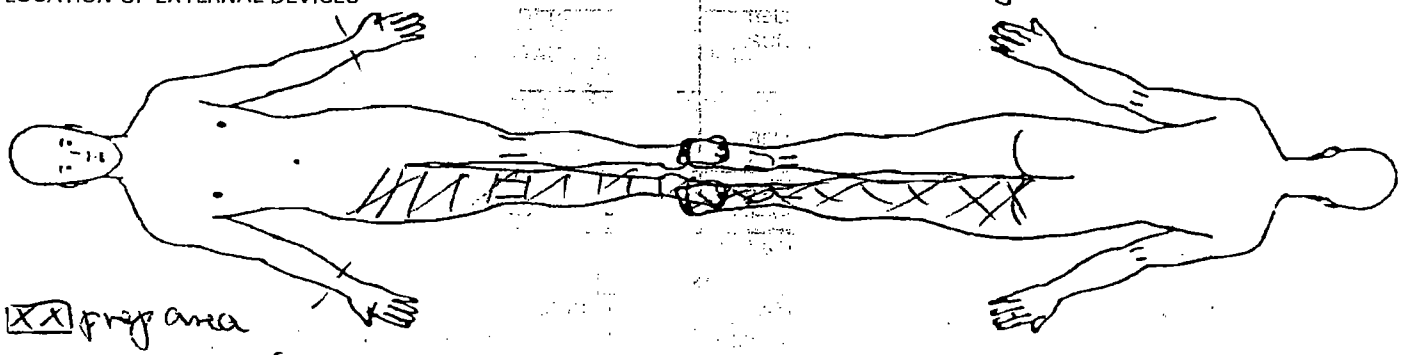
PREP SOLUTION *(Specify)* Betadine Scrub / Betadine Paint

SITE (R) leg / hip BY WHO[illegible] [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: no packing or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



XX prep area

LEGEND X Ground Pad SH → Safety Strap = = = Tourniquet

10. COUNTS — C = Correct I = Incorrect b(6)-2

			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

[redacted]

15 NOV 03 b(2)-2

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
(QS)

OTHER ORDERS	TIME	CARRIED OUT BY
none		

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 ☐

	1.	2.	3.
TYPE/SIZE	3/8 in Penrose	1in Penrose	
SITE	(R) Leg	(R) Thigh	

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

19. ADDITIONAL INFORMATION
Surgeon: [redacted] b(6)-2
Anesthesia: gustafson
-DA5179 on chart, & Δ's noted

20. OPERATION(S) PERFORMED
I+D (R) leg wounds

21. PATIENT TRANSFERRED TO PACU (ICU3) TIME see DA7389 METHOD PACU bed

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

MEDICAL RECORD — INTRAOPERA OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA stretcher BY anesthesia

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

3. DATE 26 Nov 03 TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN ROOM TIME 1338 b(6)-2 NUMBER

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	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. Hip roll Rt. hip

8. SKIN PREPARATION

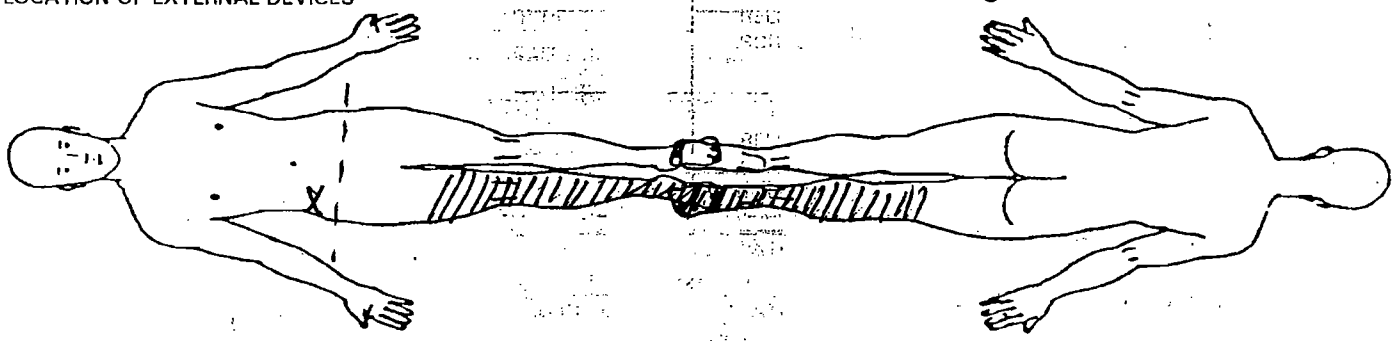
HAIR REMOVAL ☒ YES ☐ NO b(6)-2
DONE BY: ☒ OR [redacted] ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: Mult. superficial nicks

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Rt. leg BY WHOM: [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of fluids b(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [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	/	/	/		
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: Force 40 R8E105305 50/50
GROUND PAD: BRAND Valleylab REM
LOT NO: 69441

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 24226

13. PROSTHESIS, IMPLANTS ☒ YES NO IF YES NAME: ID NUMBER; M. C ER

Synthes ASIF Screw Set 6.5 cancellous part. threaded 4.5 cortical
Load # 0332802 8 hole T plate 85mm X 2 42mm 32mm
Synthes DCP Plates #24a16 80mm X 1 38mm
Load # C232905 36mm

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 YES ☒ NO ☐ C-Arm IF YES, SITE Rt. Leg

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	J P Drain 10mm	Foley 16FR	
SITE	Rt. ~~Hand~~, knee	Bladder	

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Webril
Plaster splint Ace
Rt. Leg

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] CRNA Type: General
Asst. [redacted] - b(6)-2

20. OPERATION(S) PERFORMED

1. ORIF Rt. Distal Femur
2. Removal of Ex fix

21. PATIENT TRANSFERRED TO PACU TIME 1925 METHOD Stretcher

[redacted] CPT/AN

REVERSE OF DA FORM [redacted], OCT 87 USAPA V1.00

b(6)-2

MEDCOM - 24227

MEDICAL RECORD

INTRAOPERAT[illegible]UMENT

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

PATIENT TRANSPORTED TO OPERATING ROOM
VIA stretcher BY anesthesia

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

3. DATE 9 DEC 03 TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN ROOM [redacted] TIME 1158 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: Proper body alignment maintained

8. SKIN PREPARATION

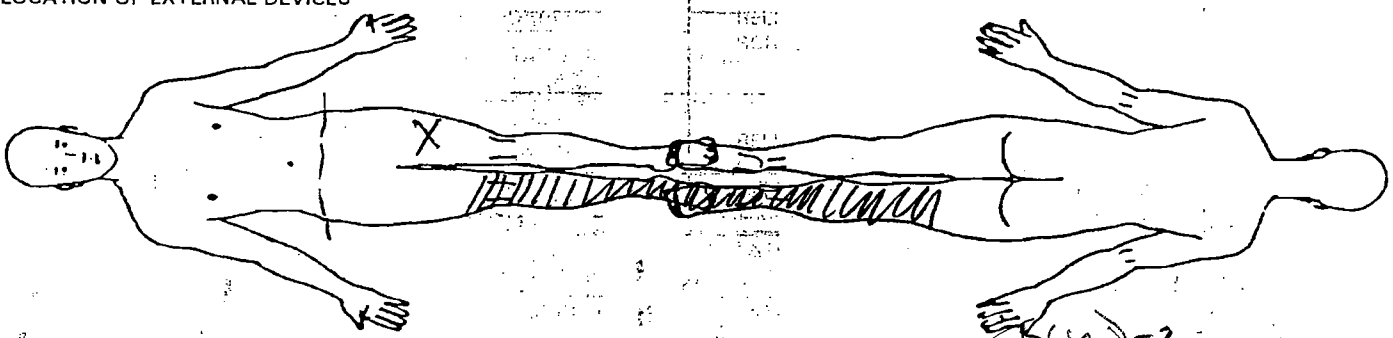
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt. lower leg BY WHO[illegible] [redacted]
SITE: BY WHO[illegible] [redacted]

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect Initial C [redacted]

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No					
Needle Sharp	☒ Yes	☐ No			C	[redacted]	[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:
GROUND PAD: BRAND
LOT NO: 69441

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

Surgical Simplex 938JJ 2007-10
cement/917JJ/2007-11

Vancomycin 39/021638 Exp 1 MAR 05 } Antibiotic beads

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Vancomycin - see above					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

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

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

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm Flat J.P. Drain	2.	3.
SITE	1. Rt. Knee	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform, Ioban, 4x8's, Fluffs, Kerlix } Rt. Knee

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] CRNA Type: General w/ LMA

20. OPERATION(S) PERFORMED

1. I&D Rt. Knee w/ placement of antibiotic beads

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU b(4)-2	1310	Stretcher

22. REGISTERED NURSE SIGNATURE

[redacted] CPT/AN

MEDICAL RECORD — **INTRAOPERATI[illegible] CUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA stretcher BY anesthesia

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

3. DATE 11 DEC 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM [illegible] TIME 0812 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 66-2	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: Bump under Rt. hip. Proper body alignment maintained.

8. SKIN PREPARATION

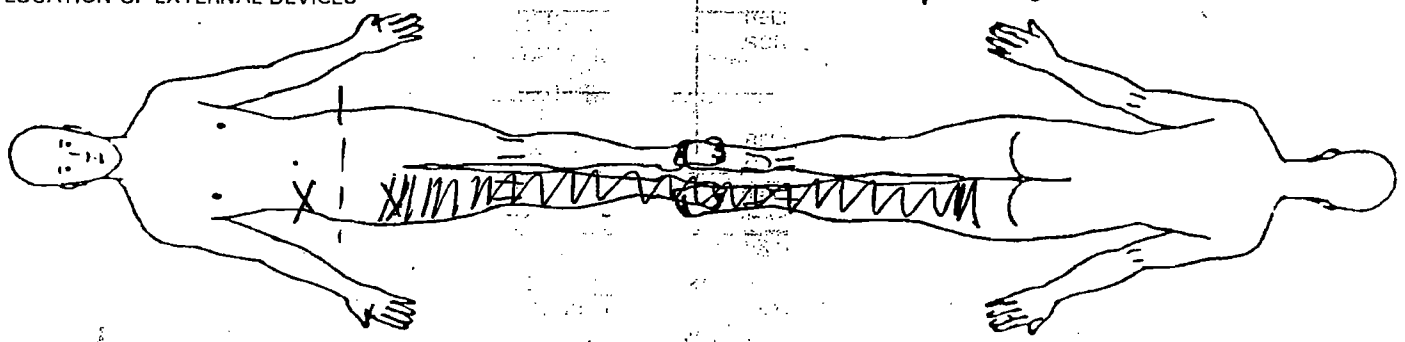
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Rt. leg BY WHOM [redacted] 66-2
SITE: BY WHOM:

COMMENTS: No pooling of fluids

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					
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

[redacted] b(2)-2

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO: 70337

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Surgical Si[illegible]® P
Howmedic[illegible] de R.L.
Raheen Bus[illegible] Park
Limerick, Ireland.
Full Dose
REF 6191 0 001
LOT CLJ157

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO IF YES NAME: ID
Tobramycin 1.2gm #3M3TS Exp. 3/05 X2

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 SIG[redacted] b(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8's
Ioban
Kerlix
Ace

19. ADDITIONAL INFORMATION
Surg: [redacted] b(6)-2 Anesth: [redacted] CRNA Type: General w/ LMA

20. OPERATION(S) PERFORMED
1. I & D Rt. Knee w/ Placement of Antibiotic Beads

21. PATIENT TRANSFERRED TO b(6)-2 PACU | TIME 0940 | METHOD stretcher

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/AN

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

For use of this form, see AR 40-407, the propon[illegible]cy 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] CPT / AN

3. DATE 26 Dec 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 16:40 b(6)-2 NUMBER (8)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Ø English Speaker.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

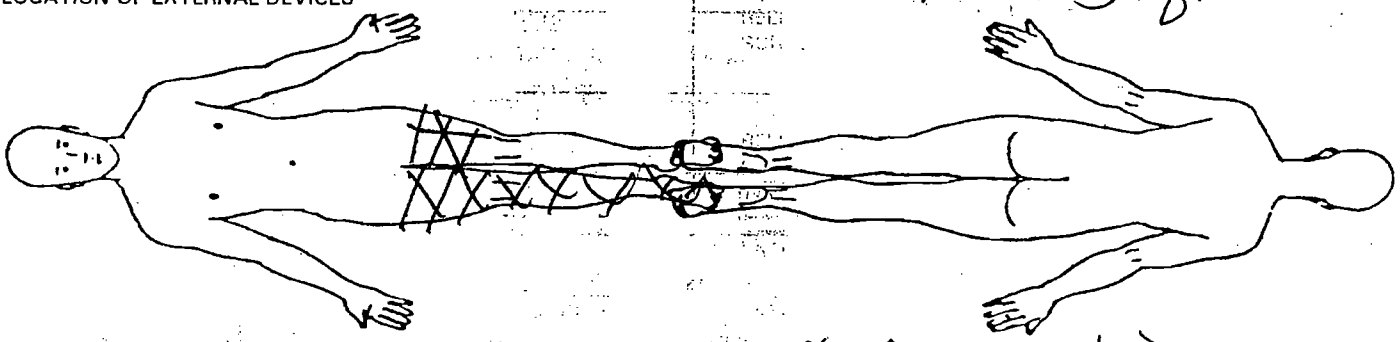
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (R) leg BY WHOM: CPT [redacted]
SITE: BY WHOM:
b(6)-2
COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet XXX - Prep b(6)-2 Circular PFC [redacted] / CPT [redacted]

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No	/	C	C	PFC [redacted]	CPT [redacted]
Needle Sharp	☐ Yes	☐ No	/	C	C	PFC [redacted]	CPT [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

[redacted] 26 Dec 03 b(2)-2

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

CUT 50 COAG 50

☒ ESU NO: Valleylab
GROUND PAD: BRAND Valleylab E7507
LOT NO: 711400 2005-05

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS [X] YES [ ] NO

Surgical Simplex® P
Howmedica Int. S. de R.L.
Raheen Business Park
Limerick, Ireland.
Full Dose
REF 6191 0 001
LOT CLJ157

BER; FACTURER
- 6 Vancomycin LOT 1777Z7 1FEB2005
C 1.2g Tobramycin LOT 3M3TS 3/05

14. IRRIGATION/MEDICATIONS GIVEN IN OPERATIN) YES [ ] NO [X]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPER[redacted] IF YES, SITE
YES [X] NO [ ] CARM (R) Knee

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [ ]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [ ]	NAME	NAME
CULTURE (C) YES [X] NO [ ]	NAME (R) Knee 1720	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES [X] NO [ ]

TYPE/SIZE	1. 10mm JP drain	2.	3.
SITE	1. (R) Knee.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix
- ace wrap

19. ADDITIONAL INFORMATION
I & D (R) knee

20. OPERATION(S) PERFORMED
I & D (R) knee, (R) knee reconstruction c̄ methyl metacrylate.

21. PATIENT TRANSFERRED TO ICU 3 b(4)-2 TIME 1820 METHOD litter

22. REGISTERED NURSE [redacted] CPT/AN

REV[redacted] OF DA FORM 5179-1, OCT 87 MEDCOM - 24233 USAPA V1.00

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY anesthesia

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

3. DATE 3JAN04 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0835 NUMBER 1-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

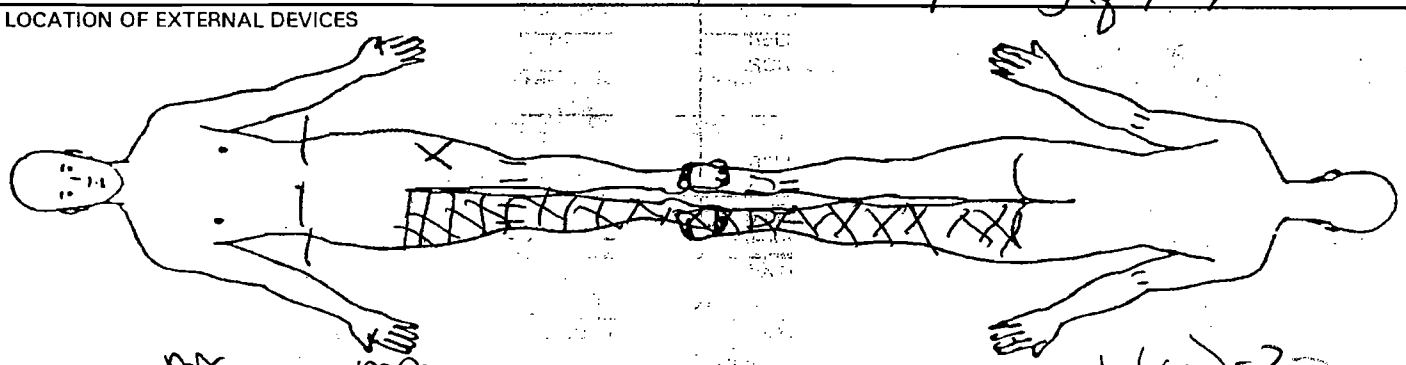
COMMENTS:

8. SKIN PREPARATION b(6)-2

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

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (R) leg BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

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

[redacted] b(2)-2
3JAN03

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

CUT 30 COAG 30

☐ ESU NO: Valleylab R8E 10530S
GROUND PAD: BRAND Valleylab E7507
LOT NO: 71140 2005-05

☐ 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

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	3/8 Penrose		
SITE	(R) Knee		

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix
- ace wrap
- Knee immobilizer

19. ADDITIONAL INFORMATION
surgeon:
Dr. [redacted]
b(6)-2

20. OPERATION(S) PERFORMED
I & D (R) knee, central line placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
litter ICU 3	1030	litter

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

b(a)-2

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY MAJ [redacted]

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

3. DATE 19 Jan 04 TIME PATIENT ARRIVED IN SUITE 1400

4. PATIENT IN ROOM TIME 1400 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(a)-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

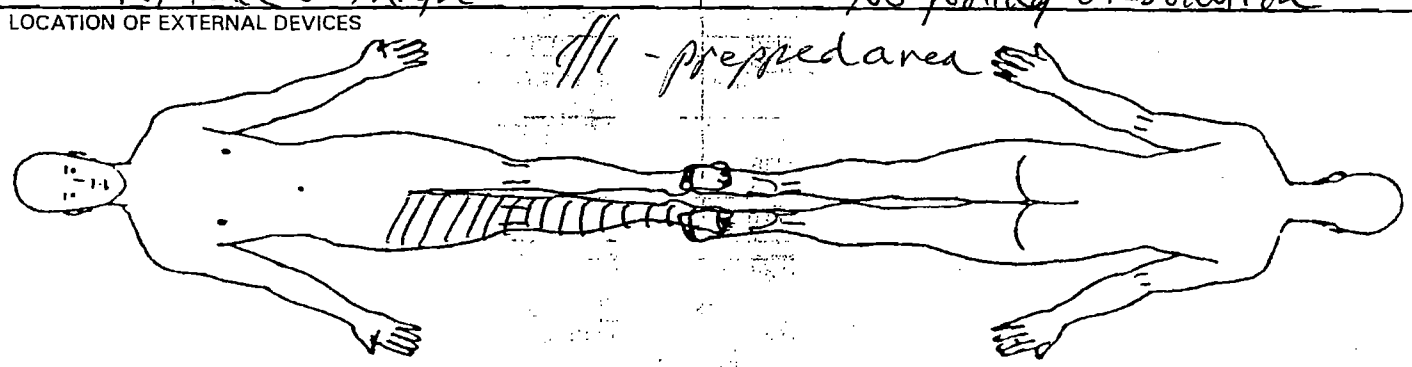
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub & solution
SITE: Rt leg BY WHOM: MAJ [redacted]
SITE: BY WHOM: b(a)-2
COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

b(a)-2

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

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

[redacted] b(a)-4

b(2)-2

19 Jan 04 [redacted]

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

Not used

☑ ESU NO: 60366
GROUND PAD: BRAND Valleylab
LOT NO: 74994 Exp 2005-09

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Cog: Out:

13. PROSTHESIS, IMPLANTS ☐ YE ☑ NO IF YES NAME; ID NUMBER; I ACTURER

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

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform
Bacitracin ointment
Fluffs
Kerlix Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] assistant: Dr [redacted]
Anes CPT [redacted] b(6)-2

20. OPERATION(S) PERFORMED

STSG to Rt knee from Rt thigh

21. PATIENT TRANSFERRED TO PACU b(6)-2 TIME See SF 517 METHOD OR Litter ō siderails up

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN (9) Jan 04

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY																	
MONTH-YEAR	DAY	12 NOV		13		13		14		15		15		16			
19	HOUR	0930	1	0900	1630	1730	2		2		7		2		2		
PULSE (O)	TEMP. F (•)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD			8	8			8	8	8	8	8	8		114/65	8		
Record special data only when so ordered	BLOOD PRESSURE	145/8	130/16	120/72			122/66	114/73	122/69	118/70	126/73			P	138/80		
		130		99				101	107	99.8	99.2			106			
		T97		T101	101		98.8	106		96	103			T	98.1		
	HEIGHT: WEIGHT →	97%		94%										97%			
		RA		RA			93%	94%	93%	94%	92%	96%		5L 94%			
							RA							95% RA			
						Pulse 97											

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

REGISTER NO.

WARD NO.

#[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

(Centigrade Equivalents, for Reference only)

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 17 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24

19 | HOUR: 0900 | 0800 | 0000 | 0800 | 0644

PULSE (O) | TEMP. F (•) | TEMP. C

105° — 40.6°

180 — 104° — 40.0°

170 — 103° — 39.4°

160 — 102° — 38.9°

150 — 101° — 38.3°

140 — 100° — 37.8°

130 — 99° — 37.2°

98.6° — 37.0°

120 — 98° — 36.7°

110 — 97° — 36.1°

100 — 96° — 35.6°

90 — 95° — 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 122/73 | 14 | 16 | 16 | 18 | 18 | 18 | 18 | 18 | 18 | 18 | 20/20

BLOOD PRESSURE: 149/79 | 135/75 | 134/71 | 127/67 | 121/74 | 128/76 | 119/65 | 131/79 | 122/57

99 | 98.6 | 98.6 | 98.6 | 98.6 | 98.6 | 98.6 | 98.6 | 98.6

SpO2: 94% | 101 | 99.4F | 99.7F | 101 | 96 | 99.6

HEIGHT: | WEIGHT →

95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% (RA) | 96% | 95%

RA | RA | (RA) | (RA) 96% RA | RA | RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

b(6) -4

511-119 NSN 7540-00-634-412

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY																	
MONTH-YEAR	DAY	14		15		16				20		22		27			
19	HOUR	4	8	12	4	8	12	4	8	12	4	8	12	2	4	8	12

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 →

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.

C[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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