Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST [redacted] (b)(6)-4	DATE / TIME	SSN/PSEUDO SSN:

(STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GL		
BU		
CA		
CR		
NA		
K^+		
CL		
tC		
T		
AL		
AL		
AL		
AM		
AS		
TB		
GG		
TP		
T		
NA		
K^+		
CL		
tC		

======= PICCOLO =======
18/11/03 04:1? AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100684

GLU	213*	73-118	MG/DL
BUN	17	7-22	MG/DL
CA++	8.4	8.0-10.3	MG/DL
CRE	1.0	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	108	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE / TIME	SSN/PSEUDO SSN:

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.020	N/A
Bld	neg	Negative
pH	5.0	N/A
Prot	neg	Negative
Urob	norm	0.2-1.0
Nit	neg	Negative
	neg	Negative
		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

LAB ID NO.:

[redacted]

Bands		Eos	
		Baso	

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/18/03 04:08

Patient ID: [redacted]
Test Name :APTT
Test Result:= 34.7 sec.
Sample Type:citrated wh. blood
Test Date :11/18/03
Test Time :04:06
Card Lot :110214
Operator [redacted]

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/18/03 04:10

(b)(6)-2

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.5 sec.
Ratio = 1.3
Calculated INR = 1.47
Sample Type:citrated wh. blood
Test Date :11/18/03
Test Time :04:08
Card Lot :080201
Operator [redacted]

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
fentanyl	(µg)	150		100		100		100		50				
(lidocaine) propofol	(mg)	(40)/100												
(succinylcholine)	(mg)	1 (80)		7		2								
	( )													
	( )													
	( )													
VOLAT AGENT	100 % del			1 →		→ (2)		→ (1)		→		→ (X)		
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	10 — (1)		→		→		→		→		→ (3)		

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → preop: ancef 1gm IVPB (EMT)

FLUIDS

LINE site														
(L) AC 18g	☐ Warmed													
(R) AC 18g	☐ Warmed (1)													
	☐ Warmed (2)			(3) →										
	☐ Warmed							(4)						

LOSSES — EST BLOOD LOSS / URINE -

TOTALS	
TOTAL EBL	75
TOTAL URINE	700
NG:	500

FLUIDS - SUMMARY

CRYSTALLOID- 3200

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) pt received, room, O2/monitors. SIVI ⊕ NGT to suction, eyes taped. easy mask vent. DVL x1 → OETT A/T → (+) ETCO2 ↑, BCBS.

(2) pt awake, opens eyes, extubated. To PACU, report.

(R) nexstig 3mg IV rocuronium 0.5mg IV

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 135 / 75 HR- 76

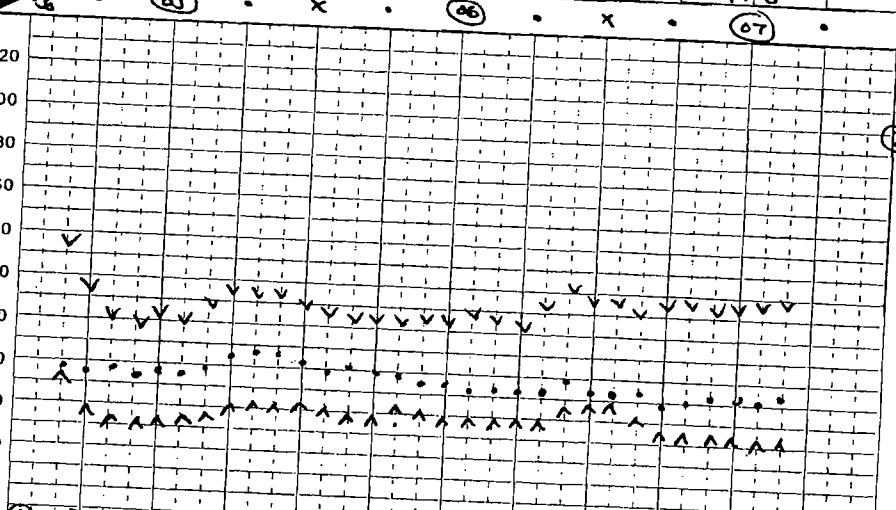
EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 0426 • (05) • X • (06) • X • (07) •

100/600 100/700

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



VENTIL

VT - ml	–	740	740	880	700	700	730	710	(R) 810	2700	(2) 750
f - breaths/min	10	10	10	8	8	8	8	8	6	8	10
Peak inf pres / PEEP	–	14	14	15	14	15	14	14	15	–	
MODE - S(pon), A(ssist), C(on)	SV	C	C	C	C	C	C	C	C	S/A	S

MONITORS/ACCESSORIES

(X) BP/Auto Cuff	(X) ET CO2 (torr)	–	32	33	30	31	31	32	33	35	54
BP/oth	(X) FIO2 (Frac or %)	66	66	66	65	66	65	59	54	51	49
ART line	(X) SpO2 (%)	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	(X) ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	(X) TEMP-site C	–	36.0	36.1	36.1	36.1	36.0	35.9	35.9	36.2	–
	N-M Block (T/4)										
Warming blkt											
Conv warmer											

RECOVERY AT 0715

(PACU) ICU _____ (Specify)

OTHER

CONDITION: stable

RESP- 12 SpO2- 100%

BP- 130/69 HR- 74

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0440	0445	0720
	Ready	Begin	End
PROC	0450	0500	0700

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → (S), BUE on boards <90° c shoulders, palms ↑

PROCEDURES and CPT Codes: expl. lap.

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

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

[redacted]

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* #8.0, OETT, 22 clip, Mac 3, A/T + see (1)

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

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: 1

DATE: 18 Nov 03

PAGE 1 OF

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ___ DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: expl. lap.
SURGICAL SERVICE: ___
NPO SINCE: ___

ASA Physical State 1 2 3 4 5 (E)
WT: ~70 (KG)/LB HT: ___ IN.
ALLERGIES: ___

HABITS:
TOBACCO: + PPD
ETOH: ___
DRUGS: ___

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) unk
( ) ___
( ) ___
( ) ___
( ) ___
( ) ___

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

LABORATORY STUDIES:
HB/HCT: ___ / ___
U/A: ___
OTHER: ___

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
unk

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ___
HEENT - Teeth intact
Trachea w/L
TMJ/Neck Fran
Oropharnyx MP II
Nares ___
CHEST: CTA
CARDIAC: S_1/S_2 - RRR
EXTREMITIES: ___
IV Access: PIV x 2
Ulnar Filling: ___
BACK: ___
OTHER: ___

NPO Since (NGT)

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

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

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

Signed: CPT [redacted] (b)(6)-2 Date: 18 Nov 03 Time: 0440 Hrs

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

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

[redacted] (b)(6)-4

SEDATION KEY:

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

(5)(6)-4

Noted 18 NOV 03 0914

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	11/18/03	0630 HOURS	
	POST OP ORDERS		
(1)	ADMIT to PACU → then ICW per protocol		
(2)	Dx: s/p EXLAP / Cholecystectomy / Repair of Stomach injury / SMALL EXPLOSION	for ABD INJ	20
(3)	Condition: GOOD		Pneumotx
(4)	VITALS per PACU protocol then Q4H on ward		
(5)	NKDA		

PATIENT IDENTIFICATION

(5)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER
(6)	BR	HOURS
(7)	IVF NPO 125 cc/hr	
(8)	STRICT I/O	
(9)	Foley to gravity	
(10)	CBC POD #1	
(11)	Phenergan 25 mg ~~PO Q~~ IV Q6° PRN N/V	
(12)	MSO4 2-10 mg IV Q2° PRN PAIN	
(13)	call H.O. if T > 100.4 SBP > 180 < 90	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER
	DBP > 100 < 40	HOURS
	P > 120 RR > 25 U.O. < 30 cc/hr	
(14)	CXR (PORT) @ 1200 hrs today 11/18 —	
(15)	NGT to LOW intermittent Suction	
(16)	~~Zantac~~ 50 mg IV Q8°	
(17)	Ancef 1 gm IV Q8° X 3 doses — next dose 1200 hrs today	[redacted] M.D. UTL MC

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF [redacted]
(18)	NPO	HOURS

[redacted]

11/18/03

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.

24P/0450 21NOV03 [redacted]

Noted [redacted] 19NOV03 0900

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
11-19-03	0834 HOURS	
(1) D/C Foley		
(2) continue I/O		
(3) OOB c̄ Assistant @ shift		
(4) Incentive spirometry use 10x/hr WA		
(5) Wet to dry to chest / suprapubic / B3 BID		HIP
Thanks!		

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER	TIME OF ORDER	
19NOV03	2300 [redacted] HOURS	MC
(1) insert Foley; if UOP > 400cc, leave foley in.		
Dr Matsumoto / [redacted]		
[redacted]		

Noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24P/0300 20NOV03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
11-20-03	0725 HOURS
(1) D/C Foley	
(2) Replace it @ void in 60	
(3) Sims / chips	
D/C NGT	[redacted]
[redacted]	

Noted 20NOV03 [redacted]

NURSING UNIT | BED NO.

24P/21NOV03@0450 [redacted]

PATIENT IDENTIFICATION [redacted]

DATE OF ORDER	TIME OF ORDER
11-21-03	0720 HOURS
(1) D/C Zantac	
(2) Advance to clear liq	
(3) if Temp > 101, Blood Cs x 2	
[redacted]	

Noted 21NOV03 0730 [redacted]

NURSING UNIT

24P/0245 22NOV03 [redacted]

(b)(6)-2

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4				11-22-03	0923 HOURS	
			1	Heplock IV		
			2	Advance to Regular Diet		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
2NO / 0300		[redacted]				

Noted [redacted] 22 Nov 03 0930

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-2				11-23-03	1003 HOURS	(b)(6)-2
			1	CXR PA/LAT		
			2	Percocet II po Q4° → pt may refuse		
			3	Encourage IS use 10x/hr WA		
			4	Encourage Deep Cough / pulmonary toilet		
NURSING UNIT	ROOM NO.	BED NO.				
[redacted]				[redacted]		

Noted [redacted] 23 Nov 03 1050

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			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4				11/25/03	0200 HOURS	
				D/C to CAmp		
				[redacted]		[redacted]
				Lte me		
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2		11/25/03 0200
ICW 1						

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

(TX FROM ICW2.)

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. NOV 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	21	22	23	24	25	26	27	28	29	30
18	[redacted]	Vitals: Q4°	[redacted]													
18	[redacted]	BR	[redacted]													
18/19	[redacted]	Strict I&O (continue)	[redacted]													
18	[redacted]	Foley to Gravity	[redacted]													
18	[redacted]	NGT to low intermittent suc	[redacted]													
18	[redacted]	BACITRACIN TO FACIAL/CHEST WOUNDS	[redacted]													
19 NOV	[redacted]	OOB/C assistance q shift	06 18 18 06													
19/23	[redacted]	incentive spirometry use 10x/hr WA	06 18 18 06													
19	[redacted]	MD to chest/suprapubic (B) hip BID (MD does and)	10 22													
20 NOV	[redacted]	Sips + chips	06 18 18 06													
21 NOV	[redacted]	Advance to Clear liq	06 18 18 06													
22 NOV	[redacted]	Advance to Regular diet	06 18 18 06													

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P EX LAP FOR SHRAPNEL INJ

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

(b)(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Nov Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18	[redacted]	CBC POD #1	19	0400		
18	[redacted]	CXR (port) @ 1200 hrs today 11/18		(ICW2)		
19 NOV	[redacted]	D/C Foley	19	1300	—	[redacted]
20 NOV	[redacted]	D/C Foley	20NOV	—	0900	[redacted]
20NOV	[redacted]	Replace if ∅ void in 6°	20NOV		1520	[redacted]
20 NOV	[redacted]	D/C NGT	20NOV	—	0930	[redacted]
22 NOV	[redacted]	XR PA/LAT	23	—		[redacted]
25 NOV	[redacted]	D/C to camp	25	1200	—	[redacted]

(b)(6)-2

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
18	[redacted]	Call H.O. if T>100.4													
----	----	SBP >180<90, P													
----	----	DBP >100 <40, P>120													
----	----	RR >25 U.O. <30cc/hr													
21NOV	[redacted]	if temp >101, Blood													
----	----	CS x2													
----	----														
----	----														
----	----														
----	----														

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												
				23	24	25										
23 Nov 03	[redacted]	Encourage deep cough [redacted]														
		pulmonary toilet [redacted]														
		(b)(6)-2														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX LAP FOR SHRAPNEL INJURY

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

(TX from ICW2)

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. NOV Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25
18	[redacted]	IVF: LRC 125cc/hr	0	[redacted]							
	-----		N	[redacted]							

18	[redacted]	Zantac 50mg IV	08	[redacted]							
	-----	Q8°	16	[redacted]							
	-----		[redacted]								

18	[redacted]	Ancef 1gm IV Q8°	04	[redacted]							
	-----	X3 doses, next dose	12	[redacted]							
	-----	1200 hrs today	20	[redacted]							
22	[redacted]	Heplock IV	06					[redacted]			
	-----		18								
			18								
23 NOV 03	[redacted]	Percocet II po Q4° -	06								
	-----	pt may refuse	04								
	-----		08								
	-----		12								
	-----		16								
	-----		20								
	-----		24								

(b)(6)-2

DC'ed 2 NOV [redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P EX LAP FOR SHRAPNEL INJ

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 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
18	[redacted]	Phenergan 25 mg	1500 18 NOV	0030 21 NOV	0810 21 NOV	22 NOV 1930	23 NOV 1930									
		IV Q6° prn n/v	25 mg IV	25 mg	25 mg	25 mg	25 mg	[redacted]								
	(b)(6)-2					(e)			(b)(6)-2							
18	[redacted]	MSO4 2-10 mg IV	11-18 0921	1123 18 NOV	1445 18 NOV	0230 19 NOV	[redacted]	19 NOV 1745	21 NOV 0745	22 NOV 0230	22 NOV 1400	23 NOV 2300	24 NOV 0500			
		Q2° prn pain	5 mg	5 mg	10 mg IV	4 mg	6 mg	4 mg	4 mg	5 mg	5 mg	6 mg	4 mg	[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 TRAUMA FLOWSHEET
The proponent is Dept of Surgery

OTSG APPROVED *(Date)* QI Appr 11 Jun 97

EMS REPORT

TIME: _____ ETA: _____ UNIT: _____

MED COM: [Y] [N]

ARRIVAL STATUS

TIME 0342 ☑ IV x 1 ☐ O_2 _____ l/min ☐ C-Spine Immob

Meds: ☑ UKN ☑ None ☐ Yes: _____

Allergies: ☐ UKN ☑ None ☐ Yes: _____

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake 2200 hrs

LMP: _____ ☐ _____

PRIMARY SURVEY

AIRWAY

☑ Natural Patient [Y] [N]

☐ ETT _____ ☐ _____

☐ Secretions _____

BRETHING

☐ Labored ☑ Unlabored ☐ Absent

TRACHEA: ☑ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] [R]

CIRCULATION

PULSE: ☑ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☑ Warn ☐ Cool ☐ Hot

☑ Pink ☐ Pale ☐ Cyanotic ☐ _____

☑ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 4 V 5 M 6 = 15

SPHINCTER TONE: ☑ WNL ☐ None

HEAD

PUPILS: ☑ Equal ☐ Fixed ☑ React ☐ Dilated [L] [R]

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ _____

JVD: [Y] [N]

HEART

RHYTHM: ☑ Regular ☐ _____

PULSES: ☐ Central ☑ Peripheral

LUNGS

BREATH SOUNDS: ☑ Bilat ☑ Equal ☑ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☑ Soft ☑ Rigid ☐ Non-Tender

☑ Tender: +

PELVIS

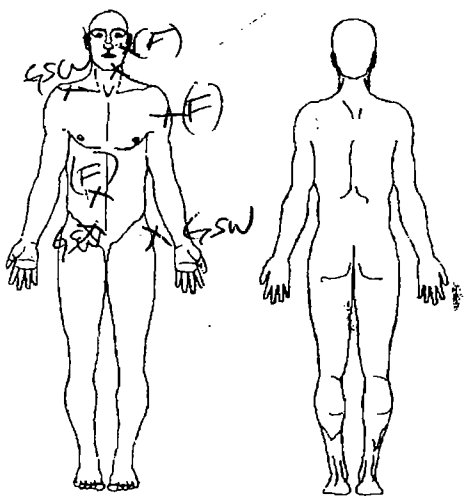
☑ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

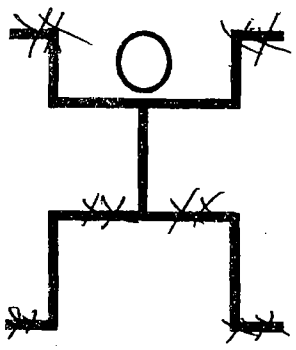
Heme +/- Prostate: ☑ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN

PHYSICIAN

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

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

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
0400	Gastric Tube	16Fr	☐ Oral ☑ Nasal	SGT [redacted]	☐ Air ☐ Contents ☐ Verified ____ Suction: Y N
0350	Urinary	16Fr	☑ Meatus ☐ Supra-Public	SGT [redacted]	☑ Return 1200 cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed	(b)(6)-2	☐ Grossly: + - Cell count Sent@ ____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac ____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac ____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick ____ ☐ SHct ____
	☐ D-stick ____ ☐ SHct ____
0354	☑ CBC ☑ Chem ☐ PT/PTT
	☐ ETOH ☑ T&S ☑ T&C x 4
	☐ Tox Screen
0400	☑ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
0350	☑ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
0350	☑ Pelvis
0350	☑ ABD
0350	☑ AP Skull
0400	☑ (L) Hip

TIME	PROCEDURE	ACCOMPANED BY	RETURN
0440	CT Scan: ☐ Contrast	EMT staff	
	☑ Head ☑ Abd ☑ Pelvis		
	☐ C-Spine ☐ T/L Spine ☑ Chest		
	☑ ~~[illegible]~~		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
0342		14	Y	N	(L) AC	NS		
0343		18	(Y)	N	(R) AC	NS		
			Y	N				
			Y	N				

MEDICATIONS

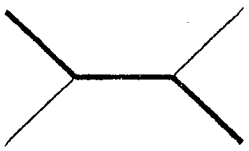
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Ancef	0355	1gm	IV						
Tetanus	0355	.5cc	IM						
Fentanyl	0400	75mg	IV						

BLOOD PRODUCTS

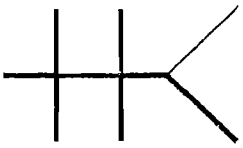
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	RWT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ ____

Admitted to ____

Report Called to ____

Time Transferred ____

Accompanied By ____

Via: ☐ Stretcher ☐ Wheelchair

VITAL SIGNS

Rectal Temp:

GCS: 15

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0345	154/71	77	NSR	35	100	RA					
0400	158/55	71	NSR	15	100	RA					
0410	174/65	89	NSR	31	100	RA					
0415	135/58	92	NSR	20	100	RA					
0420	143/66	90	NSR	24	100	RA					
	/										
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

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: 11/18/03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 0725

Allergies: NKA. OR Intake: Crystalloid 3200 Colloid

Pre-op V/S: BP 135/75 dia 76 OR Output: UOP EBL 75 cc

Procedures: Exp LOP Meds/Times: 1GM Ancef, 1gm Fentanyl

WCC SOD.

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

Pre Op Meds History

Time	0725	0730	0735	0750	0815	0830	0847
SaO2	99	99	99	99	99	99	99
FiO2	\	\	\	\	\	\	\
Methods	RA	RA	RA	RA	RA	RA	RA
240							
220							
200							
180							
160							
140	V	V		V	V	V	V
120			V				
100							
80	^	^	^	^	^	^	^
60	•						
40							
20							
LOC							
RR	18	21	24	20	13	15	
T						97.8	

Pacu Intake					
Time	Solution	Amount	Site	By	Infused
0725	LR.	300	ORARM	TU	150 cc

X-rays: Labs:

Post-Anesthesia Recovery score				
Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2	AIRWAY A = Ambu BB = Blow-by M = Mask FT = Face Tent RA = RoomAir NC = Nasal Cannula
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	V/S X = A-line BP ^ = Cuff BP = Pulse
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	TEMP S = Skin O = Oral A = Axillary T = Tympanic R = Rectal
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse				LOS C = Cervical T = Thoracic L = Lumbar S = Sacral
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10	

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)

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

DEPARTMENT/SERVICE/CLINIC: PACU - ICU 3

DATE: 11/18/03

PATIENT'S [redacted] or typed or written entries give: first, middle; gra[redacted]spital 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	ext. w.	+	+	+	B	W	Pk
15'	ext. w.	+	+	P	B	W	P/C
30'	ext.	+	+	P	B	W	P/C
45'	ext. w.	+	+	P	B	W	P/C
60'							
90'							
D/C							

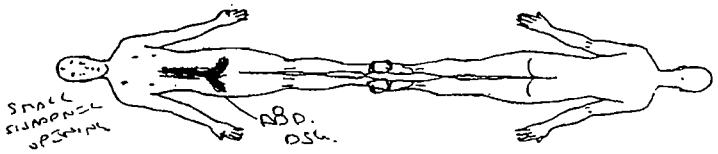
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 0725	ABD	ABD PADS	+
30' ofov	ABD	ABD PADS	+
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
0725	FOLEY.	YELLOW	100

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0725	$S_1 S_2$ +	+	

NURSING NOTES

0725 Pt arrived on floor for surgery with MD & anesthesiologist. Pt sedated, not fully awake. O_2 Room air at 100% - has NCT in (R) nostril. Pad foley. (R) gravity. Pt has abdominal dsg. midline abdomen and across lower abdomen. Pt has small puncture wounds on face and chest. Pt has clear breath sounds upon deep breathing and abdominal sounds after 57 secs. No drainage from dressings. [redacted]

0755. Pt indicated need to be on (R) side - advised to stay in supine position for proper recovery. [redacted]

0805. Pt maintaining VS, Pt allowed to rest quietly. Breathing normal, chest rise bilateral. [redacted] Pt part given to CPT O'Neal. Temp increase from 96.4 to 97.8. Pt VS stable. Awake, easily aroused, normal affect. [redacted]

(D) 0-2

Discharge Criteria:
Date: 11/18/03 **Time:** 0847 **PARS:** 10
BP: 133/82 **T:** 97.8 **HR:** 75 **RR:** 18 **Sa02:** 99%
Pain Level at D/C (0-10):
Intake: PO 150 cc **Output:** 100 cc urine
Additional Data:
Transferred To: TCW2
Report Given To: [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature [redacted]

WAMC OP 173-E

(b)(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Locatio. IZ			
3. Register Number [redacted]	Name (Last, First, MI) SI[redacted]oFirstNameGiven		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission (b)(6)-4	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. EMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 03:45	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted]; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-25		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-18		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-18		

b2-2

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW NECK, R ARM, ABDOMEN

Procedure Narrative(s):

Cause of Injury Narrative:

(b)(6)-2

Admitting Officer (Signature, as required) [redacted]	Signature of Admitting Clerk [redacted]

Automated Facsimile - DA FORM 2985, [redacted] 2000

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	(b)(6)-4	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99 20	[redacted]					ICU2	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	03:45	ABA - GENERAL SURGERY					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-A	2004-01-29					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-11-18	[redacted] b6-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
[redacted] (b)(2)-2		2003-11-18					

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW NECK R ARM ABDOMEN (LOWER EXTREMITY DEFORMITY)

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	72	72

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	72	72

Signat[redacted]	[redacted] (b)(6)-2	Signature of [redacted]

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21JAN04	(1915) VSS. C/O pain x1. Med ō 2 perc. OOB + amb in hallway. BM x1. Voids CYU. Q2° eye gtts. Tol well. Will continue to monitor. [redacted]
22JAN04 0100	Assumed care of pt. @ 2200. VSS. ¯/¯ Percocet for C/O pain to (R) buttock & joints of bilat LE. Pt. has limited vision to OU, cont. oint & GTTS to OU. Pt. sleeping @ this time, 1 pt restraint, ∅ signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] ICT, AN
22JAN04	Surgery No New Issues [redacted]
22 Jan04 1100	Assumed care @ 0600 VSS. AOO x3 → BR for showers. ∅ skin breakdown noted. Transf self from bed → chair (I). Gtts continued OU ∅ acute care needed. Will continue plan of care [redacted]
22 JAN04	(1600) VSS. C/O pain: Med ō 2 perc. Tol PO well. Voids CYU [redacted] Q2° eye gtts. OOB to amb. Will continue to monitor [redacted]
23JAN04 0135	Assumed care of pt. @ 2200. VSS. ¯/¯ Percocets for C/O pain to joints of bilat. LE. Pt. has limited vision to OU. Cont. oint & GTTS to OU. Pt. voids CYU ō difficulty. Pt. ambulated ō hands in hallway ō

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

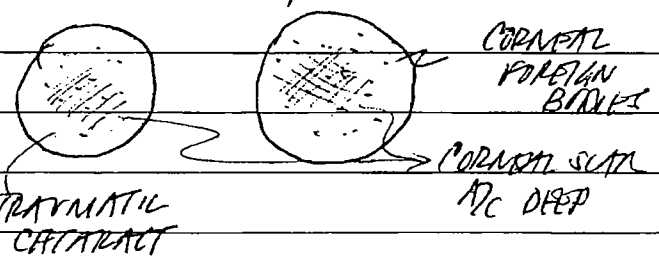
[redacted]

PROGRESS NOTES
Medical Record

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

(b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont.)	difficulty. Pt. sleeping @ this time. Pt. in 1 pt. restraint c̄ Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] 1CT, AN
23 Jan 04 0850	VSS Alert & Oriented Percocet given for c/o joint pain. Good appetite. [redacted] Reposition self in bed. Ø skin breakdown noted. One point restraints replaced without compromised skin integrity. [redacted]
23 Jan 04 1130	Informed Dr. [redacted] of pt c/o pain to lower extremity. Percocet D/C and was told to give tylenol for pain. Will inform next shift. [redacted] LTN
JAN 23 '04	Ophth ~~Optom~~ Progress Note
	S: SEEING BETTER ABLE TO RECOGNIZE STAFF AT A DISTANCE
	O: EXAM ESSENTIALLY UNCHANGED
	
	A: S/P (B) CORNEAL INJURIES c̄ FOREIGN BODIES OU. TRAUMATIC CATARACT OD, FOCAL CATARACT [redacted]
	P CPM [redacted]

(b)(6)

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

23 JAN 04 (1840) VSS. c/o pain. Med c̄ Tylenol 650mg PO. Cont eye gtts Q2° OU. (b)(6)-7 Tol [redacted]. Voids CYU. Dt down to optometry for Vup. ~~Φ A~~ Φ New orders. Ambin word. 1 pt restraint in place. Will continue to monitor. [redacted] NT/AM

24 JAN 04 Assumed care @ 2200; VSS, pt A&O, pain c̄ ii tylenol pt OOB → BSC, ⊕ BM - loose, brown stool - 2mg Loperamide provided; Φ visual Δs cont OU gtts & cont WA; pt tol PO we voiding CYU c̄ difficulty; Restraint in place c̄ comfort to skin/[redacted] circulation; Cont to monitor [redacted]

24 Jan 04 VSS A&O. Tylenol effective for pain mgt
Φ700 Good Appetite. Voiding clear yellow urine without difficulty. One pt restraint in place without compromising circ/skin integrity [redacted]

24 JAN Φ4 Surgery
No New issues
Ophtho following [redacted] (b)(6)-2

24 Jan 03 - Pt is A+OX3, no immediate distress at this time. Will continue to monitor and assess. [redacted] CT/AM

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted]
(b)(6)-7

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Jan 2040	Assumed pt care @ 2200. Pt is A+O x3; VSS; c/o H/A - Tylenol 650mg given - effective; Cont Q2° eye gtts; pt c/o pn - Motrine 800mg given - effective; pt repositioned self in bed; Ø skin breakdown noted; pt restrainted c Ø s/sx of vascular compromise / skin integrity [redacted]
25 Jan 04 0750	Assumed pt. @ 0700, VS-WNL, HEENT-WNL, pt. has LE deformity, pt. uses arms for mobility. Pt. c/o headache - gave 650mg tylenol, will continue to monitor. [redacted]
25 Jan 04 1831	Pt. in bed, ate 100% of meal [redacted] No c/o at this time [redacted]
26 Jan 04 0200	ASSumed care at 1900. [redacted] x3. PT had complaint of pain. TYLenol 650 mg was given. Ø complaints after that. VSS. TRAZOdone given for sleep. will continue to monitore [redacted] GIW
26 JAN 04	Surgery ~~Doing very well. Graft has taken well. Stump swell, open area OTW healing. None site healing.~~ wrong patient wrong patient [redacted] No New issues [redacted]
26 JAN 04 1430	Patient Bathed this Am. c/o joint pain: MD in to assess this a.m.: educated patient on importance of patient to drink ensure c meals: Drank 2 cans c lunch: VSS, neurovascular ext. intact; Resp even, regular: BS x4 quadrants [redacted]

(b)(6)-2

(b)(6)-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted]				12 Jan 04	1130 HOURS	
			①	Trazodone 50 mg po qHS for sleep		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
24 [illegible]	13 JAN 04	2350				

13 Jan 04 0915 [redacted]

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				15 Jan 04	1430 HOURS	
			①	D/C Ambien		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
24 [illegible]	16 JAN 04	0135				

(b)(6)-2

noted 16 Jan 04 [redacted]

(b)(6)-2

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
# [redacted]				19 Jan 04	1545 HOURS	
			①	D/C daily weights		
				VO [redacted]		
NURSING UNIT	ROOM NO.	BED NO.		24 [illegible] 20 JAN 04 0435 [illegible] ICT AN		

noted 19 Jan 04 1545

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]				23 JAN 03	1133 HO	
			①	D/C Percocet		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
24 [redacted]				24 JAN 04 0600		

Noted 23 Jan 04 1133 [redacted]

(b)(6)-2

DA FORM 1 APR 79 4256 PREVIOUS 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]

Duplicate order

26JAN 04 1030

NURSING UNIT | ROOM NO. | BED NO.

24° [redacted] 2UT / on 27 Jan04 0600

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
26JAN04	1020 HOURS	
(1) Zantac 150 mg p.o. BID		
[redacted]		

PATIENT IDEN[redacted]

(b)(6)-1

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
27JAN04	1010 HOURS	
(1) Motrin 800 mg p.o. BID		
Give only if fever		
[redacted]		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

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.

U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

(b)(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Location IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission (b)(6)-4	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 03:45	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: [illegible]	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
(b)(2)-2 Name and Location of Medical Treatment Facility: [redacted] Iraq; No Install Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-A	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2004-01-29		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-18		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-18		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW NECK R ARM ABDOMEN (LOWER EXTREMITY DEFORMITY)

874.9
884.1
879.3
E922.9

Procedure Narrative(s):

Cause of Injury Narrative:

(b)(6)-2

Admitting [redacted] (Signature required) [redacted]	Signature of Admitting Clerk [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

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]						FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	21Y (b)(6)-4	X				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			BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	17:15	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-12-04

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-18	[redacted]

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-18	

31. Selected Administrative Data

Marital Status: DoB: 1982-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

INFECTED R HAND/OD CORNEAL STRING

883.1
442.89
815.00
882.1
041.85
364.41
998.89
E993

19NOV03
86.28
86.04
38.82

21NOV03
86.28

23NOV
86.28
86.59

24NOV
97.89

(b)(6)-2

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	17	17

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	17	17

Signature of Att[redacted]al Officer	Signature of PAD or Medical Records Officer
[redacted]	[redacted] MA[redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

23 yo ♂ injured by bomb 10 days ago.
Has been in Iraqi hospital for surgery to (R) eye. Admitted for injury (R) eye. Also state can't see out of (R) eye, and mass on (L) cheek. I suspect (R) middle finger

PMH (-)

NKDA (+) tobacco

PHYSICAL EXAMINATION

RE (R) eye with ptosis
mass 2x2 cm mass (L) cheek fixed, nontender
NECK: supple
EXT: 3x6 cm skin loss over dorsum of (R) hand and slight middle finger, and M.F. with splint broken at wrist, hand, very tip M.F. and broken at tip.

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

xrays - P_1 + P_2 fxs, positive OK.

Plan: I to tomorrow
consult ophthalmology

(b)(6)-2

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	18 Nov 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
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR (41 CFR) 101-11.505
OCTOBER 1976
JCAHPO 7-80

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date: 18 Nov 03 Diagnosis: infected (R) hand 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** 20

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:_____ Size: _____ Drainage: _____
Tubes: _____ Appearance:_____
Dressing change:_____

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

See notes 19 Nov 03 for info. on infection of (R) foot

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 NOV 03	2030 - VSS, A+O assumed care of pt. @1800. LS CTA (B), NSR, S1S2 present, Resp. even, unlabored abd. soft. non-tender, BS x 4. voiding cyu per urinal. Pt. (R) eye swollen half-way shut c̄ (+) redness to eye + (+) film covering eye. Pt. has 1 in. incision to (L) cheek c/o pain 650mg tylenol given for swelling + pain. Pt. has numerous old scabs to upper legs. Pt. had very old drsng to (L) foot. dont think it was assessed prior to coming to ICW 2. 1" x 1cm wound c̄ (+) s/sx infection. light greenish substance oozing from wound. Redressed wound c̄ 4x4s. (+) Pedal pulse + (+) Radial pulses. (+) cap refill. Pt. has drsng to (R) Arm. Denies movement of fingers. (+) cap refill. IV (L) AC infusing 150cc/h LR. Two pt. restrain in place. Pt. resting well @ this time will cont. to monitor pt. [redacted] I concur with above assessment [redacted]
2330	- Pt. pulled out IV. New IV started in (L) FA BG Infusing LR @ 150cc/h [redacted] will cont. to monitor. Pt. [redacted]
20 NOV 03	(1650) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb well. Dsg to (R) hand Δd this am WTD c̄ Betadine soln. Pt able to move fingers. Dsg to (R) foot Δd WTD Lac. on (R) side of face CDI. (R) eye swollen/red

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19Nov0300520	Pt admitted to ICW I from EMT in Fair condition; VSS, pt A&O speaking arabic; ⊕CMS +3PP, brisk cap Ref throughout; NV intact; S, S2, LSCTA, ⊕BSX4, pt voiding QS, clear yellow urine via urinal; pt NPO for OR 19Nov03; ⊖C/O pain, pt denies N/V; dsg to ® hand cDI, ⊖drainage; Restraints in place, ⊕circ, ⊖skin breakdown, will cont to monitor [redacted]
19Nov03 1500	Assume care of PT @ 0600. A&O, VSS ambulate to bathroom without any assistance. C/O pain was given two percocets. Went to OR to wash out hand suppose to be going again tomorrow. PT may lose ® hand. In apt restraint on 2x legs. Will cont. to monitor. 9/W SPC [redacted]
	(1800) I concur c above. [redacted]
19Nov03 1821	PT went to OR for a second time due to Dr. [redacted] and Dr. [redacted] ~~poping an artery in the base of~~ #1351. Pressure applied to wound until departed for surgery. Dark red squirting blood. PT returned from OR stable condition. Will cont. to monitor. 9/W SPC [redacted]
	(1820) I concur c above. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] (5)(6)-4

(5)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20NOV03 (1605Ø)	(cont) SL in ⊖ forearm flushes well ⊼ S/Sx infection/ infiltration. 2 point restraints in place ⊼ S/Sx complications. Will cont to monitor [redacted]
21Nov03 00445	Assumed care @1800; USS, pt A&O speaking arabic Ø c/o pain @ this time; pt amb ⊼ difficulty; dsg to (R) hand Δd ⊼ Dakin's Soln. (+) CMS, +2 PP, brisk cap Ref to affected extremity; Loc to (R) check CDI, dsg to (L) Foot CDI S/L in (L) FA patent, cont ⊼ IV abx; Restraints in place (+) circ, (⊖) skin break ↓, cont to monitor; pt NPO p MN for OR on 21Nov03 — [redacted]
21 Nov 03 1217	assumed care Ø600 pt awake + oriented x 3 vital sign stable. Pt had Ø c/o of pain at the time, pt ambulated to BR with little difficulty to perform self AM care. Pt given 7 lacs prior to (R) forearm/hand dsg Δ with dakins solution WAD, Pt IV patent and intact Ø signs infection dsg to (L) FA Δd CDI. Restraints x2 in place with monitor. [redacted] (5)61-2
	Concur ⊼ above assessment [redacted]
21 NOV 03 1630	[redacted]
21Nov03 2100	Assumed Pt care @1800. A&O VSS. LSCTA(B) S1S2 present HRRR, (+) BS x4 quads (R) Hand Dsg

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.
		ICU

[redacted] (5)61-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0C

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 NOV 03 @ Cont.	DC IV to (L) FA. IV Ad to (L) [redacted] FA. Pt c/o Pain to [redacted] (R) cheek. Small amount of edema to to cheek. Percocet controlled pa[redacted] Pt void spontaneously c/v v ≤ difficulty. gs. Will [redacted] to monitor. [redacted] 91WM6
22 NOV 03 @ 1630	Assumed care of pt. @ 0600. VSS. A[redacted] ~~c/o pain this shift~~. ERROR [redacted] 11 Percs. for pain & DRSNG Δ to (R) hand. (R) hand cleaned ≈ DAKIKIAN's sol., dry DRSNG Δ, ace-wrapped, mod. serosang drainage to old DRSNG, penrose drain intact, sutures intact. IVSL infiltrated, new IV site to (L) FA, 20G. Pt. has scab over (R) eyelid, sclera red, pt c/o pain. Will arrange for opthamology consult. Pt. to be NPO ~~p~~ MN tonight for surgery. Pt. in 2-point restraints. Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] 2CT, AN
22 NOV 03 (1900)	VSS. Alert & Oriented. (R) hand dry dry & intact and covered ≈ ace wrap. (L) FA Saline lock patent & intact. (L) chest incision with staples well approximated. Assessed 80% of regular diet. Ø c/o pain @ this time. 2 restraints in place. [redacted] without compromise skin integrity or circulation. [redacted] 2CT
23 NOV 03 @ 1600	Assumed care of pt. @ 0600. VSS. A&O. Ø c/o pain to (R) hand. c/o pain to (R) eye. MD notified. Pt. to O.R. this AM for I&D of (R) thumb. Pt. received @ 1100 via stretcher from PACU. VSS A&O, Ø c/o pain. Dressing to (R) UE CDI. Pt. in 2-point restraints. Ø signs of skin breakdown. IVSL to (L) FA flushes well. All other assessments WNL. Will cont. to monitor. [redacted] 2CT, AN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 NOV 03 1330	Orthopedic Op Note
	Pre-Op Dx - Infected (R) MF
	Post Op Dx - Same
	Procedure - I&D (R) MF
	Surgeon - [redacted]
	Findings - Wound skin not fully healed to allow rep vacuum drainage. 3 liters. Pus found at still 2*2 cm defect to bone
	Plan - repeat I&D in 48 hours. Pump vacuum therapy.
	(b)(6)-2 [redacted]
	COL [redacted]
23 NOV 03 0950	Orthopedic Op Note
	Pre-Op Dx - Infected (R) MF
	Post Op Dx - Same
	Procedure - I+D by MF
	Surgeon - [redacted]

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

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

[redacted] (b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	GBL - BL FLUIDS: SGD LR
	Tentoja - Minimal purulent drainage. Irrigated 3 times. Closed with 2-0 prolene over pressure
	Plan: Dressing change. Consider wound resection if drainage continues
	[redacted]
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

☆ U.S. GPO:1998-432-786/75236

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

23 NOV 03 [redacted] 1900

VSS Alert & Oriented. (L) FH Saline lock patent & intact. (R) hand bulky dry covered c HCC wrapping dry/intact. Ø c/o pain @ this time. Capillary refill to (R) fingers brisk. Pt [redacted] able to move (R) fingers unable to palpate (R) radial pulse. Pt drsg. Consume 80% of dinner. Urinary clear yellow urine. OOB → BR for BM. Will continue care as planned [redacted] 2CPT

Ophtk Note

11/24/03

0 — 8-0 vicryl suture in cornea. 2° melting

cornea blood staining

1154 18,19

(b)(6)-2

Imp: Focal Corneal Melt 2° to Inflam From Suture - Removed

Plan: Doxy 100mg po qD

Pred Acetate Gtts OD Q1°; Cilxin Gtts OD QID

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		ID NUMBER
	LAST	FIRST	[redacted]
DEPART./SERVICE	HOSPITAL OR MEDICAL FAC[redacted]		

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. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24NOV03	(1650) VSS. Pt c/o pain in (R) eye. Med ō 2 perc. Adequate relief found. (R) eye Red around sclera. Pt slightly closed. Pt able to open eye ⅀ manual assistance. Pt receiving IV ABX. Infusing to (R) FA IV. ⊖ signs of infections. (R) hand dressed ō Kerlix + ace wrap. ~~Thumb appears~~ Pt able to move fingers + warm to touch. Pt asleep at this time. Urinates clear yellow. [redacted]
25NOV03@0510	Assumed care @ 1800; VSS, pt A&O speaking arabic; Ø c/o pain; dsg to (R) hand Δd W→D ⊂ Dakin's Sol 1/4% strength; wrapped ⊂ Kerlix; ace bandage; (R) eye swollen, sclera Red; pt instructed on administration of Pred acetate Q1° OD, pt verbalized good understanding via interpreter; S/C patent, Flushes well ⊂ ⊖ sx infection/infiltration; cont ⊂ IV abx; Restraints in place, ⊕ circ, ⊖ skin break + / cont to monitor [redacted]
25NOV03	(1800) Pt ⊖ c/o pain. Completed DSG Δ to (R) Hand. Sutures in place, well approximated. ⊖ signs of infection, Pt unable to flex 3 finger 2° damage to ~~flexor~~ extensor tendons. Able to Flex. (+) radial pulse, brisk cap refill. ~~WT + Continuous~~ [redacted] IV ABX infusing. [redacted]
26NOV03@0250	Assumed care @ 1800; VSS, pt A&O speaking arabic; Ø c/o pain; dsg to (R) hand ~~Δd~~ CDI, ⊖ drainage; +2 radial pulse, brisk cap ref, ⊖ sensation; PIV patent, easily flushes; cont ⊂ IV abx; ~~gets~~ to OD; ~~Δd~~ pt OOB to BRX1; Restraints in place, ⊕ circ, ⊖ skin break +, cont to monitor [redacted]
26NOV03@1600	Assumed care of pt @ 0600. VSS, A&O. ~~#1~~ Percocet given as prescribed for DSG Δ; WTD DSG Δ to (R) hand ⊂ Dakin's sol., sutures intact, scant serous drainage. Pt. OOB, ambulated in hallway steady gait. HL to (L) FA, flushes well. Prednisone Acetate GTTS given to pt. Q1° while awake, pt. administered GTTS. Pt. in 2 point restraints, Ø S/Sx of skin breakdown. All the assessments WN [redacted]

STANDARD FORM 509 (REV. 5/1999) BACI

USAPA V1.0

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
26 Nov 03 1800	Pt AAO. USS. LS CTA (B), HRRR, (+) BS x4 quads. (R) Hand in Drsg c̄ Ace Wrap. Small amount of Sero Sang on Drsg. (R) Eye is Red. exc ~~7~~ gtts q 1°. IV to (L) FA D/Cd. New IV to (L) FA. Cont Antibx. Pt voiding CYU. qs c̄ difficulty. Will cont to monitor [redacted] Spc 91WM6
	Opthalmology
11/28/03	S: pt still c̄o discomfort. FOP-18 2 days ago
	O: taking IV levo & pilocarpin (b)(6)-2
	topical cipro & maxitrol
	topical pred acetate → improving inflam
	doxy to prevent further thinning
	penlight: +2-3 inflam
	corneal blood staining
	Imp: (1) s/p hyphema 2° corneal blood staining - continues to improve
	(2) CMI [redacted] 6074 LTC.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27NOV03 1630	Assumed care of pt. @ 0600. Pt. resting quietly in bed. VSS. A&O, Ø c/o pain to (R) hand. c/o pain to (R) eye. ii Percocets given, Prednisone i GTTS Q1° while awake. WTD Dsg Δ to (R) hand, small amount of serous drainage to dorsal hand, sutures intact, fingers edematous, (R) hand elevated on blankets. IVSC to (L) FA, flushes well. Pt. is 2-point restraints, Ø signs of skin breakdown. All other assessments WNL, Will cont. to monitor. [redacted]
27Nov03 1900	Pt care assumed @ 1800. Pt c/o mild sharp pain to Right eye. eye gtts cont. Pain controlled ī percocet. (R) hand Dsg CDI. Neuro ✓ WNL. LS CTA (B), HRRR. (+) BS x 4 quads. Pt cont Antibiotics via 18G To (L) FA. Pt in 2pt restraint Will cont [redacted] to monitor [redacted] 91WM6
28 NOV 03 0800	Assumed care of pt. A&O x3. US[redacted] Ø c/o pain or discomfort @ this time. Lungs clear HRRR Active BS x4 quads Urinating spontaneously ī difficulty IV ABX TX cont Eye drops to (R) eye cont. (R) hand wound bulky dsg applied. Afebrile Ø s/s of infection Will cont to monitor [redacted] 91WM6
28Nov03	Assumed care @ 1800. A&O x3 USS c/o pain Percocet [redacted] @ 1800. Right eye [redacted] scalera is red. cont gtts. (R) hand Dsg is CDI. cont Primaxin IV. Voiding spontaneous [redacted] CVU [redacted] gs, ī difficulty. LAC IV failed New 18G IV in (L) [redacted] arm. Will cont to monitor. [redacted] 91WM6

STANDARD FORM 509 (REV. 5/1999) BACH
USAPA V1.0

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 Dec 03	Orthe Discharge Note:
0930	Admitted 18 Nov with infected open middle finger wound provided problems, eventually grew acinetobacter and Enterobacter. It had repeated I&Ds done, with eventual clean wound. Skin closed with prolene. Extension tendon to MF were destroyed. PLAN: Discharge to camp. Keflex 250 mg P.O. QID. If infection returns/spreads, will need middle ray resection. Many wash with soap and water. No treatment for fracture.
	[redacted] 802 MC
	(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. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.00

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 NOV 03 0730	- Assumed care pt A to x3. VSS Ø c/o pain Lungs clear b.lat HRRR Active BS x4 quads Urinating spontaneously ī difficulty per usual Ambulates ward. (R) hand wound dsg kerlix wrapped CDI. Appt ī eye dr this am see note Remains Afebrile Will cont to monitor ——— [redacted]
1 NOV 03 1900	VSS Alert & oriented O/O/B + BR Ad Lib (R) hand bulky dry dry & intact covered ī Ace wrapping (L) EA Saline lock patent & intact. Multi eye gts installed to OD Keeps OD shut. OD sclera pink. Consumed 50% of dinner. Urdy clear yellow urine c/o pain is discomfort which c the tape 2 point restraints replace without compromising circulation is skin integrity. Will continue care as planned. [redacted]
30 NOV 03 0800	- Assumed care of pt. A&O x3. VSS c/o pain x1 medicated ī relief. (R) eye slight redness cont ō eye drops per order. (R) hand wet & dry dsg & Kerlix wrap CDI - Lungs clear HRRR Active BS Urinating spontaneously. PIV (L) bicep patent Ø s/s of infection will cont to monitor ——— [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.)* | REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30NOV 2000	VSS alert/oriented. OD c̄ pink exudate. Multi, eye gtts instilled as ordered. (L) FA balance lower patent & intact. (R) hand bulky dry dry & intact. OOB (I) to BR c̄ supervision. Ø c/o pain voiced or noted. Will continue care as planned. 2 point restraints in place without compromise circulation or skin integrity. [redacted]
Ø1DECØ3	(153Ø) Assumed care @ ØØØØ. Pt alert, speaking Arabic. VSS. Ø c/o pain @ this time. Dsg to (R) hand Δd this am. Pt medicated c̄ MSØ4 prior to dsg Δ - tol. well. Amb s̄ difficulty in hallway. OOB to chair - tol. well. Cont. eye gtts as ordered. (L) eye red and swollen. SL in (L) upper arm d/c'd d/t infiltration. leg IV started in (L) forearm flushes well s̄ s/sx infiltration. Tol reg diet well. voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted]

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

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1 DEC 03 2000	VSS. Alert & oriented. Consumed 80% diet. OOB → BR (I) upon supervision of MP's. (L) FA saline lock patent & intact. Voiding clear yellow urine. (R) hand splint dry, dry & intact. OD sclera pink. Multi gtt instilled as ordered. OOB for BR throughout shift to encourage position b. to prevent skin breakdown. Skin dry & intact. 2 point restraints in place without compromising skin integrity and circulation [redacted]
02DEC03	(0200) Assumed care of 0000. Pt alert, speaking Arabic. VSS. 0 c/o pain. Pt amb in hallway s̄ difficulty. Dsg to (R) hand ∆d. sutures to incision c̄ d̄ s̄ s/sx infection. Pt tol. well. SL in (L) forearm flushes well s̄ s/sx infection/infiltration. Cont. OD gtts as ordered. Sclera of OD pink, area around OD swollen. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted] (0510) SL in (L) forearm d/c'd d/t infiltration. catheter intact. 18g IV started in (L) hand flushes well s̄ s/sx infiltration. monitoring. [redacted]
2030	- assumed care of pt. @ 1800. VSS - A+O speaking in Arabic. 0 c/o pain @ this time. Pt ambulated to toilet ⊖ BM. Sutures to (R) hand intact c̄ ⊖ s/sx inf. Pt. has FROM to fingers + wrist c̄ ⊕ cap refill. ~~ab~~ IV in (L) FA c̄ ⊖ s/sx inf. flushes well. ⊕ skin integrity. encouraging

STANDARD FORM 509 (REV. 5/1999) BACI
USAPA V1.0

[redacted]

(b)(6)-4

(b)(6)-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 NOV 03 1250	Quick Op Note Pre-Op Dx: Infected open fracture (R) mx with soft tissue loss Post Op Dx - same Procedure: I+D (R) hand Surgeon: [redacted] Findings: Necrotic fibrin. Portions of mx P, exposed to air, necrotic Plan: IV abx. Repeat I+D vs mx resection 21 NOV 03
	[redacted]
19 NOV 03	Brief Op Note Pre-op Dx = Facial Artery Aneurysm Post op Dx = SAA Procedure = Debridement, evacuation of hematoma + Ligation of facial artery Findings = Pseudoaneurysm of (L) facial artery, ligated Complications [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
NOV 18 2003	S: Intake of prisoner from DIF Prisoner was injured from IED (His) Wounds on Right hand, Right abdomen and right side of his face. Incident happened 1 week prior to exam. Right Eye - No Sight
	O: Back side of right hand, Skin peeled away signs of infection. Signs of infection in wound on left cheek.
	A: Soft tissue injuries from IED. Fracture to right middle metacarpill.
	P: R' hand wound dorsal surface 1/2 dorsal of RM digits no pain inflamation pain slight greenish discharge normal and pulse are negated Flush saline Neuling gauze sterile 4x4 Placed and cling
1440	~~Ancef 1g IM~~ Rocephin 1g IM Sit [redacted]
1440	~~Tetanus~~ Tox. Sol 1 IM
	sling Rt arm [redacted] (b)(6)-2

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

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

DIF

[redacted] (b)(6)-4

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

CoB 109th ASMB
BIAP IRAQ

558-103 (See Instructions on Back of this Sheet) (b)(2)-2 NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FA[redacted]

LOG NUMBER

ARRIVAL DATE (DAY)	MONTH	YR.	TIME
18	NW	93	1730

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

CURRENT MEDS. (Tetanus immunization and other data): Ø

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): S/P IED x 1 wk (on 2)

SEX: M AGE: 22

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER:

VITAL SIGNS			
TIME	1730		
BP	123/70		
PULSE	121		
RESP.	16		
TEMP.	97.8		
WT. (Child)			

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

ORDERS	INITS.	TIME
Tetanus (SDR)	[redacted]	1750
S Thomas		1800
2G Unasyn		1900
Percocet 4		2100

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: 23 yo EPW injured 1 week ago in IED explosion. Sent here because of ↑ pain (R) hand & probable infection.

O: A & O NAD

Face - (+) (L) cheek wound/shrapnel / nodule c̄ scant drainage & induration

(R) eye - blown pupil ō light perception

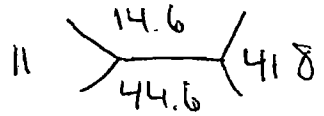
Heart - RRR Lungs - CTAB

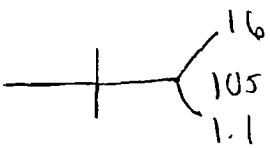
Abd - soft, nontender

(R) forearm - (+) burned (2nd degree) compartments soft

(R) hand - (+) open, punctured dorsal 2nd/3rd metacarpal wound
2+ radial pulse
Sensory & motor intact

X-rays
Face - (-) fb, ? fx.
chest - no acute ds.
(R) hand - (+) 3rd MC / prox. phalanx fx.
(R) forearm - (-) fx or fb





A: (1) Open, supportive (R) hand fx.
(2) abscess (L) cheek

P: (1) Unasyn 3.0gm IV
(2) Pain meds
(3) ortho consult

[redacted] (b)(6)-2

(CONTINUE ON SF 507, IF NEEDED)

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

[redacted]

[redacted]E OF PROVIDER AND ID STAMP

[redacted] MC

Plan(s) (include medications ordered, any limitations and follow-up)

PP/Specialist

[redacted] (b)(2)-2

[redacted] (b)(6)-4

MEDICAL RECORD

CONSULTATION SHEET

(b)(2)-2

REQUEST (b)(6)-2

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
[redacted] Surgical	[redacted]	11/18/03

REASON FOR REQUEST (Complaints and findings)

Middle aged male SSM ICD Rt hand injury
R stable & wrap Rt wrist Pain Rt jaw
R stable Pain Rt hand & strength

PROVISIONAL DIAGNOSIS

1) Severe trauma Rt hand Fx 3rd metacarpal Proximal Phalanx
2) Lacerated carpal ligaments Rt hand

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[redacted] (b)(6)-2		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE		DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER (SSN or Other)

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

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-68)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted] (b)(6)-4

510-112 NSN 7540-00-634-412

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 Dec 03	(cont'd)		pt. to Δ position Q2° to prevent skin breakdown. Tolerates reg. diet well. Cont. acetate gtts OD Q1° while awake as ordered. Pt. resting in bed @ this time will cont. to monitor pt. — [redacted] I am cm 2 alone assess [redacted]
03Dec03		1310	Assumed care @ 0900. Pt alert, speaking Arabic. VSS. C/O OD pain. Cont OD gtts as ordered. Sclera red, eye swollen. (R) hand open to air. Sutures to incision CDI ∅ S/Sx infection. Pt OOB to shower this am. SL in (L) hand d/c'd d/t pt's request. IV 20g started in (R) ac flushes well ∅ S/Sx infiltration. Tol. reg diet well. Voiding ∅ difficulty. 2-point restraints in place ∅ S/Sx complications. Will cont. to monitor. — [redacted] 2
		2200	- assumed care of pt. @ 1800. VSS - A+O pt speaking in arabic. ∅ c/o pain @ this time. (R) hand sutures intact OTA ∅ S/Sx inf. SL in (R) ac ∅ S/Sx inf. infiltration. voiding c/u. ∅ difficulty. cont OD gtts. (+) skin integrity. pt. resting in bed @ this time ∅ two pt restraints. will monitor [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] (b)(6)-4 [redacted] NURSING NOTES Medical Record

MEDCOM - 24889

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
04DEC03	1700		NSB. VSS. ∅ c/o pain. Ambo steady gait. Maj [redacted] informed that pt to be D/Ced to Camp. Transfer summary taken to PAD. Rx taken to pharmacy. IV ABX given. Dr [redacted] D/ced sutures from (R) hand. Voided in urinal ∑ difficulty. IV D/Ced by Spc [redacted] Dr [redacted] informed pt of poss. Amputating (R) 3rd finger. Pt verbalized understanding through interpretor. pt escorted out of hospital by MPs. [redacted]
			(b)(6)-2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

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

2. PATIENT IDENTIF[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE 19 Nov 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	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: Pt on OR table c̄ both arms out sides on padded armboards

8. SKIN PREPARATION

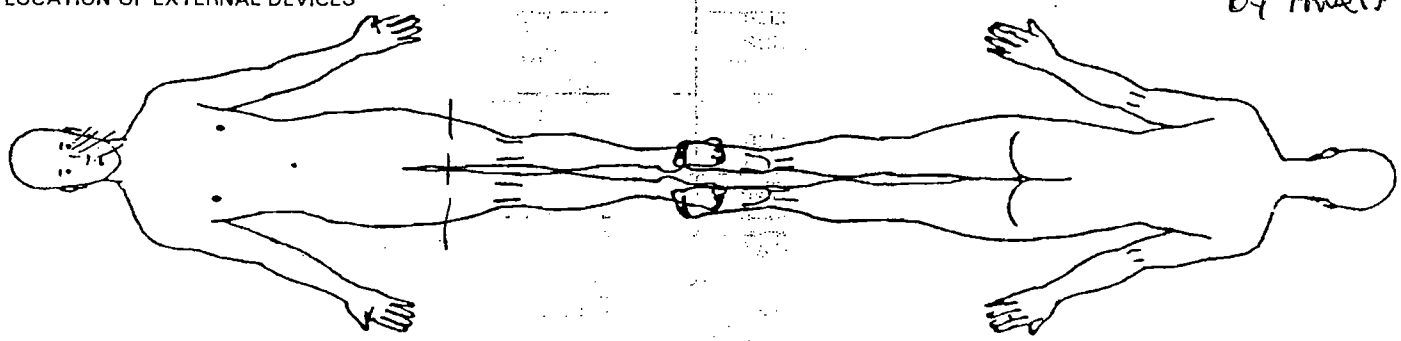
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine & saline
SITE: Lt foot BY WHOM: MAJ [redacted]
SITE: BY WHOM:

COMMENTS: Pooling of solution contained by towels

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					
Needle Sharp	☑ Yes	☐ No		C	C	SPC [redacted]	MAJ [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

(b)(2)-2

19 Nov 03 [redacted]

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

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

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

☐ BIPOLAR NO: _____

(b)(6)-2

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine Zep	4 ml	intra op	Local	MAJ [redacted]	Dr [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Bacitracin ointment

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]

Anes: CRT [redacted]

20. OPERATION(S) PERFORMED

Debridement of facial wound, Evacuation of hematoma rt cheek, Ligation of artery

21. PATIENT TRANSFERRED TO PACU TIME Sep 5 1517 METHOD OR Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

2. PATIENT IDENTIF[illegible] [illegible]RD REVIEWED AND PROCEDURE
VERIFIED BY MAJ [redacted]

3. DATE 19 Nov 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER 7-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	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: Pt on OR table w/ both arms at sides on padded armboards

8. SKIN PREPARATION

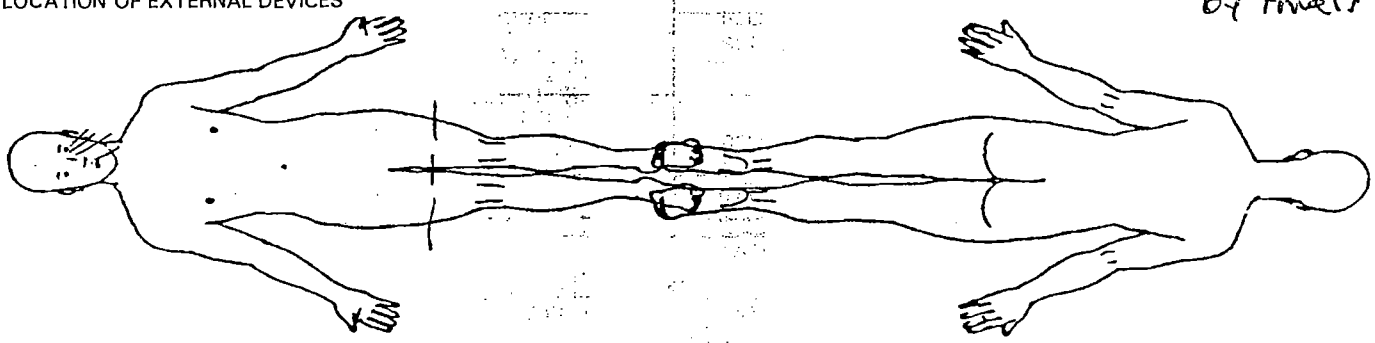
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine in saline
SITE: Lt face BY WHOM: MAJ [redacted]
SITE: BY WHOM:

COMMENTS: Pooling of solution contained by towels

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					
Needle Sharp	☑ Yes	☐ No		C	C	SPC [redacted]	MAJ [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

(b)(2)-2

19 Nov 03 [redacted]

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 ☐ NO IF YES NAME: ID NUMBER: ACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine-Epi	4 ml	intraop	Local	MAJ [redacted]	Dr [redacted]
					(b)(6)-2

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)*

Bacitracin ointment

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]

Anes: CRT [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

Debridement of facial wound, Evacuation of hematoma left cheek, Ligation of artery

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	See 5F517	OR Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 24894

T TRANSPORTED TO OPERATING RO
Her BY MAJ [redacted] VERIFIED BY MAJ [redacted]

TIME PATIENT ARRIVED IN SUITE 1150 — 4. PATIENT IN ROOM TIME 1150 NUMBER 1-1

Jan 03

5. PREOPERATIVE EMOTIONAL STATUS

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

TS:

6. NURSING PERSONNEL

GNED JB	SGT [redacted]	RELIEF SCRUB	
IGNED CULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

ITION AND POSITIONAL AIDS *(Specify)*

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

ENTS: Rt and Lt arms on padded armboard at angle < 90°

8. SKIN PREPARATION

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

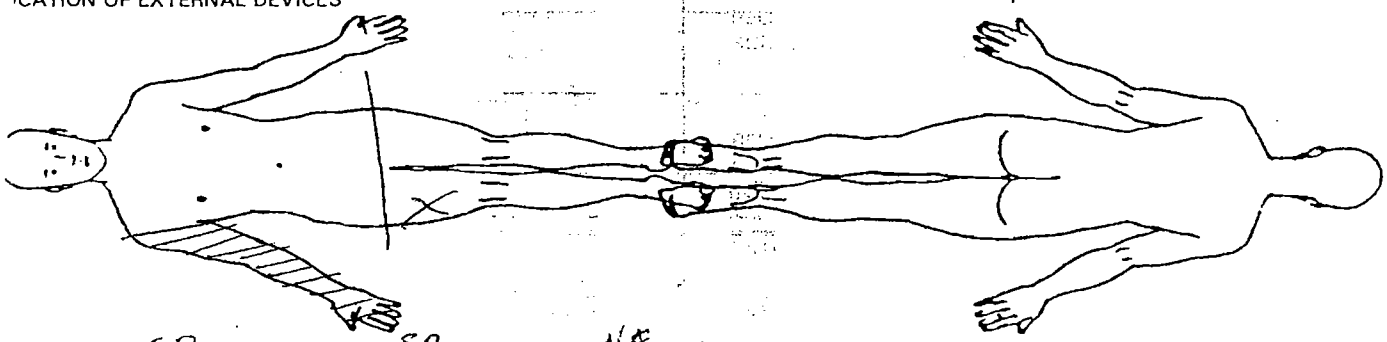
MENTS:

PREP SOLUTION *(Specify)* Betadine scrub + solution
SITE: Rt arm BY WHOM: MAJ [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of solution

(b)(6)-2

CATION OF EXTERNAL DEVICES



EGEND X Ground Pad (ED) -- Safety Strap (ED) = = = Tourniquet (NA)

C = Correct I = Incorrect

COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
nge	☑ Yes	☐ No		C	C	[redacted]	[redacted]
dle Sharp	☑ Yes	☐ No		C	C		
rument	☐ Yes	☑ No				SGT	MAJ
er	☐ Yes	☑ No					

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

[redacted] (b)(6)-4

(b)(2)-2

9 Nov 03 [redacted]

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

☐ ESU NO: RES 102395
GROUND PAD: BRAND Valleylab
LOT NO: 69441 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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): N.S.

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 (c) swabs x2 of Rt hand wound	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☑ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]
anes: MAJ [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I&D Rt Hand

PATIENT TRANSFERRED TO	TIME	METHOD
PACU	See SF517	OR Litter & siderails up

REGISTERED NURSE SIGNATURE

[redacted] MAJ AN 19 Nov-03

EASE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL ...

PATIENT TRANSPORTED TO OPERATING ... IA Stretcher BY anesthesia

2. PATIENT ... VERIFIED BY [redacted]

DATE 1 Nov 03 TIME PATIENT ARRIVED IN SUITE →

4. PATIENT IN ROOM TIME 1244 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

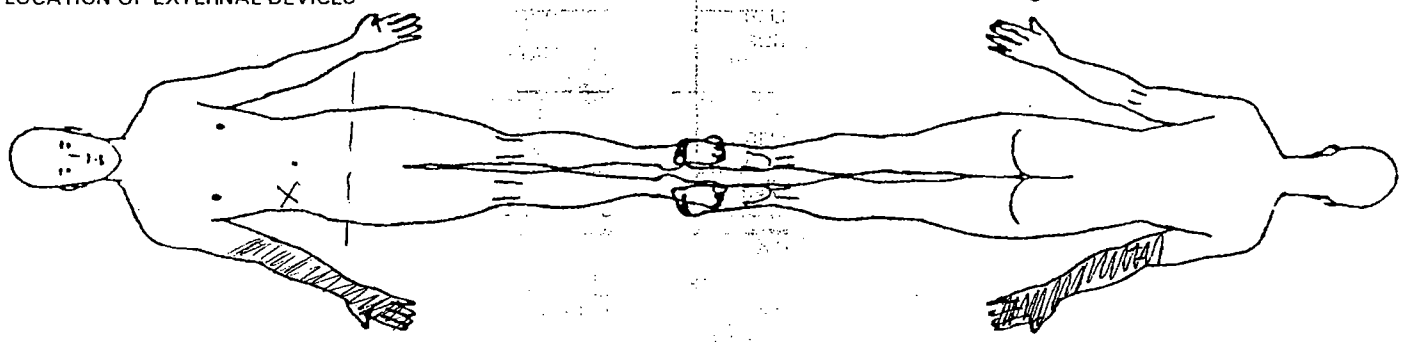
PREP SOLUTION *(Specify)* Betadine scrub/soln

SITE: Rt arm BY WHOM: [redacted]

SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

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

☐ ESU NO: Force 4D R8E10530S 30/30

GROUND PAD: BRAND

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 Penrose	2.	3.
SITE	1. Rt. hand	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] Type: General w/ LMA

(b)(6)-2

20. OPERATION(S) PERFORMED

1. I & D Rt. Hand

1. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1338	Stretcher

2. REGISTERED NURSE SIGNATURE

[redacted] CPT/AN

1. PATIENT TRANSPORTED TO OPERATING SUITE VIA Litter BY MAJ [redacted] VERIFIED BY MAJ [redacted]

3. DATE 23 Nov 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] 66F	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Both pt's arms on padded armboards at angle < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

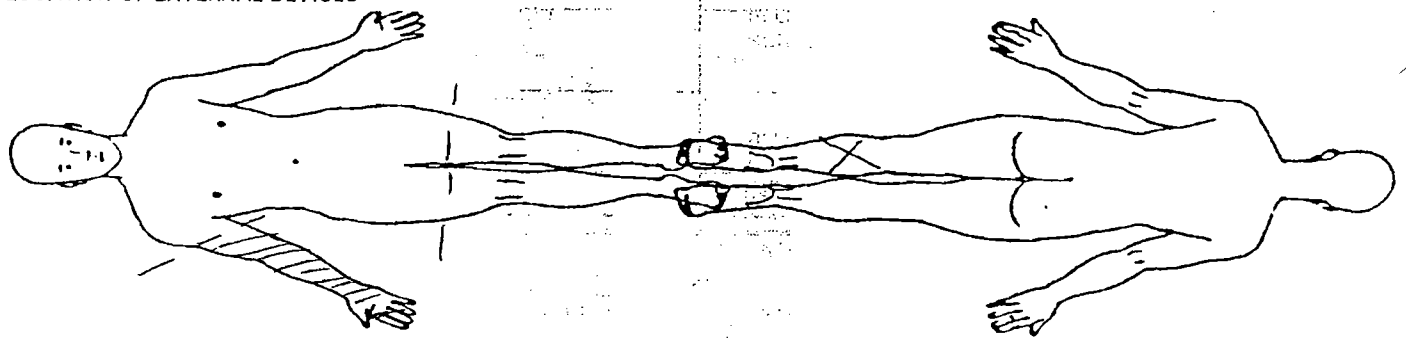
PREP SOLUTION *(Specify)* Betadine scrub & solution

SITE: Rt arm BY WHOM: MAJ [redacted]

SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C		
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)(6)-4

(b)(2)-2

23 Nov 03 [redacted]

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

☑ ESU NO: R8B 102395

GROUND PAD: BRAND Valleylab

LOT NO: 69441 Exp 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

Coag 30 Cut 30

(b)(6)-2

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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): N.S.

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. 3/8" Penrose	2.	3.
SITE	1. Rt hand	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Ace

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]
anes: MAJ [redacted]

(5)(6)-2

20. OPERATION(S) PERFORMED

I&D Rt ~~arm~~ middle finger

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU.	See SF517	OR Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 23 Nov 03

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

IEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
DAY																	
TH-YEAR NOV/DEC	DAY	25		26		27		28		29		30		01			
2003	HOUR	2		0	2	0	2					0	2	1	2		
		0		7	1	5	2					9	0	2	1		
				3	0	4	0					0	0		6		
				8	0	0	0					0	0		0		

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

		8		4		8	8		7			8	8		8		

Record special data only when so ordered

BLOOD PRESSURE		120/69		105/55	104/52	103/RA		110/60				108/49	108/43	98/47	108/40		
				97.9				97.9									
				64	98.2	98.0		56				57					
HEIGHT:	WEIGHT →																
		98% RA		98%, 97% RA		98% RA 98% RA		98%			98%	98%, 98% RA			98% RA		

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

REGISTER NO.

WARD NO.

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

[redacted] (b)(6)-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- NOVEMBER DAY

MONTH-YEAR Nov 19 2003 | DAY: 18, 19, 19, 20, 21, 22, 23, 23, 24

HOUR

PULSE (0) | TEMP. F (•) | TEMP. C (Centigrade Equivalents, for Reference only)

105° 40.6°
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 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

BLOOD PRESSURE ① 107/53 | 118/62 | 132/66 | 118/65 | 124/60 | 120/67 | 124/62 | 120/67 | 116/56 | 114/45
②

①TEMP 97.0F | 98.5 60 | 97.6 98.8 | 122/64 | 98.7 98 | 98.7 | 98.4 | 97.4 | 98.6
HEIGHT: WEIGHT ②TEMP 100%

① O2Sat 98% | 98% RA | 97% RA | 98% (RA) | 98% RA | 98 | 98 100% RA RA | 97% RA | 98% RA
SOURCE
② O2Sat 98% RA
SOURCE

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] (5)(61-4

VITAL SIGNS RECORDS

Medical Record

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC 2003 | DAY: 02 03 04

HOUR: 08 12 4 8 12

PULSE (0) | TEMP. F (°)

105° 100 100 100

180 104°

170 103°

160 102°

150 101°

140 100°

130 99° 98.6°

120 98°

110 97°

100 96°

90 95°

80

70

60

50

40

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 104/47 108/49 114/50 112/51 124/48 80 99

HEIGHT: WEIGHT →

O2 Sat: 98(RA) 99% 98(RA) 99% 98% 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)

#[redacted] (6)161-4

REGISTER NO.

WARD NO. ICU1

STANDARD FORM 511 (REV. 7–95) BACI

[redacted]OSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name #[redacted] (b)(6)-4
First Name:
Patient # or SSN [redacted]

Collected by: Dr [redacted]
Date: 19 Nov-03
Time: 12-15
for anaerobic + aerobic cultures

Received by [redacted] (b)(6)-2
Date: 19 NOV 03
Time: 1400

Ward: ICW 1
Room:
Bed:
Physician: Dr [redacted]

Source: Wound
Site: Rt Hand

Specimen #: CV134

Laboratory Results

Enterobacter cloacae
Acinetobacter baumannii

Reported
Date: 21 NOV 03
Time: 1000
Tech: IC
Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 24904

Name:
Patient ID: [redacted] (5)(b)-7
Ward/Rm: W1/

Specimen: W134
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Enterobacter cloacae Status: Final
2 Acinetobacter baumannii/haemolyticus Status: Final

1 E. cloacae

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>16	R
Aztreonam	>16	R
Cefazolin	>16	R
Cefepime	16	I
Cefotaxime (c)	>32	R
Cefotetan	>32	R
Cefoxitin	>16	R
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	2	I
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Moxifloxacin	<=2	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	<=4	S
Ticar/K Clav (a)	>64	R
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

2 Ac baumann/haem

Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	
Amp/Sulbactam (c)	<=8/4	S
Ampicillin	>16	
Aztreonam	>16	R
Cefazolin	>16	
Cefepime	>16	R
Cefotaxime (c)	>32	R
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	R
Ciprofloxacin	>2	R
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	
Gentamicin	>8	R
Imipenem (c)	<=4	S
Levofloxacin	4	I
Meropenem (c)	<=4	S
Moxifloxacin	<=2	
Nitrofurantoin	>64	
Norfloxacin	>8	
Piperacillin (a)	>64	R
Tetracycline	<=4	S
Ticar/K Clav (a)	<=16	S
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases. potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S 8-16=I >16=R). Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci refer to the penicillin interpretation. Footnote (a) also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin for Gram Negative isolates and trovafloxacin are based on FDA approved breakpoints. For S. pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections use (<=2=S 4=I >=8=R)

Name:
Patient ID: [redacted] (5)(b)-7
Ward/Rm: W1/

Specimen: W134
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected: (5)(b)-2
Req. Phys: [redacted]
Tech: I. C.

Printed 11/21/2003 2:12:17 PM

[redacted] HOSPITAL
[redacted]
Baghdad, Iraq (b)(2)-2

Microbiology Request Form

Last Name #[redacted]
First Name: (b)(6)-4
Patient # or SSN: [redacted]

Collected by: Dr [redacted]
Date: 19 Nov 03
Time: 1215
for anaerobic + aerobic cultures

Received by [redacted] (b)(6)-2
Date: 19 Nov 03
Time: 1900

Ward: ICW 1
Room:
Bed:
Physician: Dr [redacted]

Source: Wound
Site: Rt Hand

Specimen #: CN134

Laboratory Results

Enterobacter cloacae
Acinetobacter baumannii

Reported
Date: 21 NOV 03
Time: 1000
Tech: IC
Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 24906

Name: [redacted] | Specimen: **W134** | Status: **Final**
Patient ID: | Source: Wound/Sterile site | Collected:
Ward/Rm: W1/ | Ward of Iso: | Attd. Phys:

1 Enterobacter cloacae — Status: Final
2 Acinetobacter baumannii/haemolyticus — Status: Final

1 E. cloacae

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>16	R
Aztreonam	>16	R
Cefazolin	>16	R
Cefepime	16	I
Cefotaxime (c)	>32	R
Cefotetan	>32	R
Cefoxitin	>16	R
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	R
Cephalothin	>16	R
Chloramphenicol	>16	R
Ciprofloxacin	2	I
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Moxifloxacin	<=2	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	<=4	S
Ticar/K Clav (a)	>64	R
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

(b)(6)-4

2 Ac baumann/haem

Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	
Amp/Sulbactam (c)	<=8/4	S
Ampicillin	>16	
Aztreonam	>16	R
Cefazolin	>16	
Cefepime	>16	R
Cefotaxime (c)	>32	R
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	R
Ciprofloxacin	>2	R
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	
Gentamicin	>8	R
Imipenem (c)	<=4	S
Levofloxacin	4	I
Meropenem (c)	<=4	S
Moxifloxacin	<=2	
Nitrofurantoin	>64	
Norfloxacin	>8	
Piperacillin (a)	>64	R
Tetracycline	<=4	S
Ticar/K Clav (a)	<=16	S
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase Appears in place of Sensitive with species known to possess inducible beta-lactamases, potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended Avoid other/combined beta-lactam drugs

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation Footnote (a) also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002 Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis For non-meningitis infections, use <2=S, 2=I >2=R

Name: | Specimen: **W134** | Status: **Final**
Patient ID: [redacted] | Source: Wound/Sterile site | Collected:
Ward/Rm: W1/ | Ward of Iso: | Req. Phys: [redacted]

(b)(6)-2

Tech: I O [redacted]

(b)(6)-2

Ward/Section:	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M: [redacted]	DATE: 8 NV	TIME: 1230	SSN/PSEUDO SSN: [redacted]

(b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE

Misc. Serology

TEST	RESULT	REF. RANGE

======= PICCOLO =======
18/11/03 18:26
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA/
OPER #: 678 DR #: 000
SERIAL #: 0000100434

ALB	3.9	3.3-5.5	G/DL
ALP	85*	26-84	U/L
ALT	15	10-47	U/L
AMY	62	14-97	U/L
AST	25	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
GGT	10	5-65	U/L
TP	8.3*	6.4-8.1	G/DL

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

======= PICCOLO =======
18/11/03 12:24 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100684

GLU	105	73-118	MG/DL
BUN	16	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	339	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(5)61-2

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST: [redacted]	DATE: (5)61-7	TIME: 1734	SSN/PSEUDO SSN: [redacted]

(STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^{+}		128-145 mmol/l
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^{+}		3.3-4.7 mmol/l
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^{-}		98-108 mmol/l
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
BEecf		(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	**(Piccolo) Metlyte 8**			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA^{+}		128-145 mmol/l	**(Piccolo) Electrolyte**		
Troponin-I			K^{+}		3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL^{-}		98-108 mmol/l	NA^{+}		128-145 mmol/l
			tCO_2		18-33 mmol/l	K^{+}		3.3-4.7 mmol/l
						CL^{-}		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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)	1145	1200	15	30	45	1300	15	30	45
Fentanyl	50g/cc	50								
	( )									
	( )									
	( )									
	( )									
VOLAT AGENT	~~Forane~~ % del									
	Ultane % e.t.	1-3	2¼	1¾	1-1					
AIR	L/Min									
N2O	L/Min									
O2	3 L/Min									

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

FLUIDS

LINE site		1145	1200	15	30	45	1300	15	30	45
	☐ Warmed									
	☐ Warmed									
RL-1000	☒ Warmed						700			
	☐ Warmed									

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

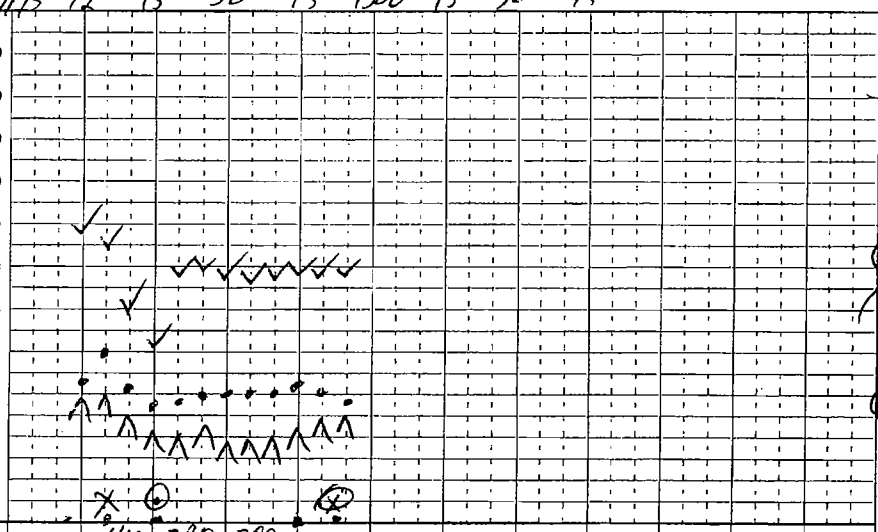
HEMATOCRIT:

INITIAL DATA: BP- 135 155; HR- 66 90

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

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



VENTIL

	1145	1200	15	30	45
VT - ml	410	390	380		
f - breaths/min	12	12	11	10	
Peak inf pres / PEEP	—	—	—		
MODE - S(pon), A(ssist), C(on)	AS	AS	AS	S	

MONITORS/ACCESSORIES

		1145	1200	15	30	45
✓ BP/Auto Cuff	✓ ET CO2 (torr)	55	48	50		
BP/oth	✓ FIO2 (Frac or %)	69	53	72		
ART line	✓ SpO2 (%)	99	100	100	99	
Steth- PC/ES	✓ ECG	SR	SB	SR	SB	
✓ 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)

TOTALS	TOTAL EBL
	<5
	TOTAL URINE

FLUIDS - SUMMARY: CRYSTALLOID- 700cc; COLLOID-; BLOOD-

REMARKS — Code drugs with numbers, events with letters

(1) V/S Taken
(2) Induced c̄ Fentanyl/ 50µgm Lidocaine 20mg Diprivan 150mg Anectine 60mg O2 Ultane LMA inserted
(3) Procedure began
(4) Procedure ended
(5) Breathing well, O2, To recovery

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____

CONDITION: RESP- 10 SpO2- 99 BP- 115/49 HR- 56

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1144	1157	1253
	Ready	Begin	End
PROC	1208	1216	1245

PROCEDURES and CPT Codes: W/O (R) hand wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Gen

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #4 LMA

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

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

SURGEON [redacted] (b)(6)-2

ANESTHETIST [redacted] CRNA

PROCEDURE LOCATION: OR

DATE: 19 Nov 03

PAGE (OF

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "|"=CONSTANT INFUSION		
DRUG	(Units)	
Propofol	( )	150
Sux	( )	100
Fentanyl	(cc)	2
	( )	
	( )	
	( )	
VOLAT AGENT: Iso	% del	3 – 2
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3-2-2-8
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

TOTALS	
150	
100	
2	

TOTAL EBL: 100

TOTAL URINE: —

FLUIDS – SUMMARY

CRYSTALLOID– 320

COLLOID–

BLOOD–

FLUIDS			
LINE site	CR	☐ Warmed	300 – 1000
		☐ Warmed	
		☐ Warmed	
		☐ Warmed	
LOSSES	EST BLOOD LOSS		
	URINE –		

REMARKS–

Code drugs with numbers, events with letters

Ed'd / chart reviewed. To OR #2. Prepped left L cheek. Monitors, Pre O2. Smooth RSI & LP gas typical shift

Sx. Extubated & (+) pneu to 100% mask – To PACU.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

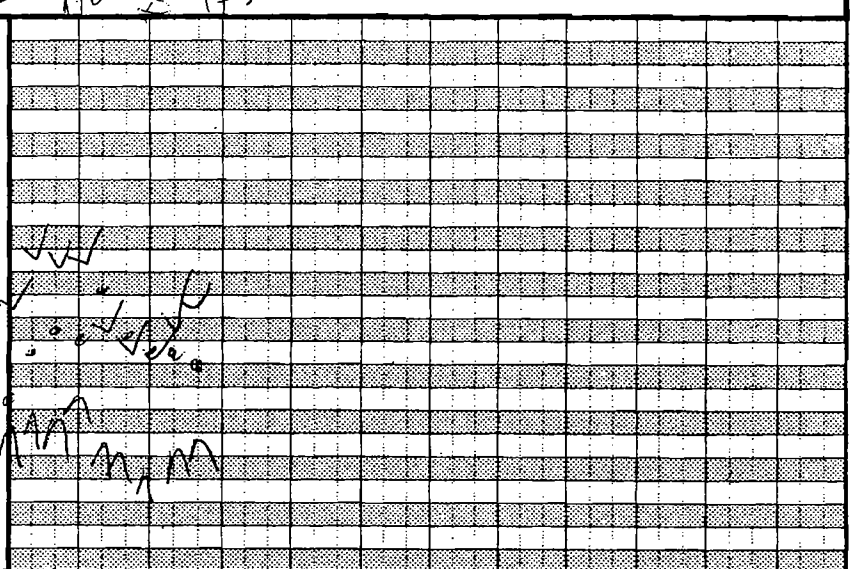
INITIAL DATA: BP – 113/59; HR – 71

COMP CHECK: OK? – Y / N

PATIENT RECHECK: OK for PROCEDURE? ✓ TIME –

TIME → 1700 – 1730

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



VITALS				
VT – ml		700	750	700
f – breaths/min		8	10	6
Peak inf pres / PEEP		30	19	19
MODE– S(pon), A(ssist), C(on)		S/CV	CV	CV/CV
MONITORS & ACCESSORIES				
BP/Auto Cuff	ET CO2 (torr)	41	35	48
BP / oth	FIO2 (Frac or %)	.50	.77	.80
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	SR	ST	ST
Gas analyzer	TEMP- site			
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS

Position → Supine

RECOVERY AT: PACU / ICU ____ (Specify) / OTHER ____

CONDITION: AT

RESP– 16 SpO2– 98%

BP– 131/61 HR– 82

ANESTHESIA PROVIDER TIME

	Start	Room	End
ANES	1645	1650	1725
	Ready	Begin	End
PROC	1655	1706	1720

PROCEDURES and CPT Codes

debridement of facial wound / evacuation of hematoma (L) CHEEK & ligation of artery

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

DL x 1 MAC #3 #7.0 ETT (+) VC (+) ETCO2 (+) B=BS

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

[redacted]

(b)(6)-4

SURGEONS: [redacted] (b)(6)-7

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR #2

DATE: 19 Nov

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)	1145	1200	15	30	45	1300	15	30	45
Fentanyl / 50µg/cc ( )		50							
( )									
( )									
( )									
( )									
VOLAT AGENT: ~~Forane~~ % del									
VOLAT AGENT: Ultane % e.t.		1-3	2¼	1¾	1				
AIR L/Min									
N2O L/Min									
O2 3 L/Min									
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →									

FLUIDS

LINE site		1145	1200	15	30	45	1300	15	30	45
	☐ Warmed									
	☐ Warmed									
RL - 1000	☒ Warmed						700			
	☐ Warmed									

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 135 155; HR- 66 98%

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

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

VENTIL

	1145	1200	15	30	45
VT - ml	410	390	380		
f - breaths/min	12	12	11	10	
Peak inf pres / PEEP	—	—	—		
MODE - S(pon), A(ssist), C(on)	AS	AS	AS	S	

MONITORS/ACCESSORIES

		1145	1200	15	30	45
✓ BP/Auto Cuff	✓ ET CO2 (torr)	55	48	50		
BP/oth	✓ FIO2 (Frac or %)	69	73	72		
ART line	✓ SpO2 (%)	99	100	100	99	
Steth- PC/ES	✓ ECG	SR	SB	SR	SB	
✓ 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)

TOTALS: TOTAL EBL <5; TOTAL URINE

FLUIDS - SUMMARY: CRYSTALLOID- 700cc; COLLOID-; BLOOD-

REMARKS — Code drugs with numbers, events with letters

(1) VS Taken
(2) Induced c Fentanyl / 50µg/cc, Lidocaine 20mg, Diprivan 150mg, Anectine 60mg, O2, Ultane & LMA inserted
(3) Procedure began
(4) Procedure ended
(5) Breathing well, O2, To recovery

RECOVERY AT: PACU ICU _____ (Specify); OTHER _____

CONDITION: RESP- 10 SpO2- 99; BP- 115/49 HR- 56

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1144	1157	1253
	Ready	Begin	End
PROC	1208	1216	1245

PROCEDURES and CPT Codes: W/O (R) hand wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Gen

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #4 LMA

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

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

SU[redacted] (b)(6)-2

ANES[redacted] CRNA

PROCEDURE LOCATION: OR

DATE: 19 Nov 03

PAGE 1 OF

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

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

DRUG (Units)																	
Fentanyl 50 µg/ml		150															
( )																	
( )																	
( )																	
( )																	
( )																	
VOLAT AGENT	Sevo % del	3-2.5-2-1															
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2 3	L/Min																

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

FLUIDS

LINE site																	
RL-600	☐ Warmed																
	☐ Warmed																
	☐ Warmed																
	☐ Warmed																

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP- 114 158; HR- 73 98%

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 1245 1300 15 30 45 1400

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

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

VENTIL

VT - ml	460	520		
f - breaths/min	12	10	14	
Peak inf pres / PEEP	19	17		
MODE - S(pon), A(ssist), C(on)	CV	CV	SA	

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	37	39	
BP/oth	✓ FIO2 (Frac or %)	71	69	
ART line	✓ SpO2 (%)	100	100	100
Sneth- PC/ES	✓ ECG	SR	SB	SB
✓ 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)

TOTALS — TOTAL EBL <5; TOTAL URINE

FLUIDS - SUMMARY — CRYSTALLOID- 150; COLLOID-; BLOOD-

REMARKS

Code drugs with numbers, events with letters

(1) U/S Taken
(2) Induced c Diprivan 150 mg Anectine 60 mg O2, Sevo LMA inserted
(3) Procedure began
(4) Procedure ended
(5) O2 breathing To recovery

RECOVERY AT PACU ICU _____ (Specify) OTHER _____

CONDITION: Stable 97
RESP- 13 SpO2- 100
BP- 119/65 HR- 63

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1231	1244	1342
	Ready	Begin	End
PROC	1306	1308	1329

PROCEDURES and CPT Codes: W/O R hand wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GEN

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

[redacted] (b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #4 LMA

SUR[redacted] (b)(6)-2

ANESTHETIST [redacted] CRNA

PROCEDURE LOCATION:

DATE: 21 Nov 03

PAGE 1 OF

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

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	Grid: x 30 x 1000	TOTALS	TOTAL EBL
MSO4	(MG)	2 2 2 ... 1 1 1	10mg 10	minimal
Propofol	(mg)	150 50		
LHCL	(mg)	<40		TOTAL URINE
Fentanyl	(Mcg)			Ø
	( )	50 ... 50	200 mcg	
	( )			
VOLAT AGENT Sevoflurane	% del / % e.t.	2 6-2-3~2—1.5 x		FLUIDS - SUMMARY
AIR	L/Min			CRYSTALLOID- 500ml
N2O	L/Min			COLLOID- Ø
O2	L/Min	4 2— 2— 2—4		BLOOD- Ø

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

FLUIDS

LINE site: 18g (L) FA — ☐ Warmed — 300 — 500

☐ Warmed ☐ Warmed ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE - Ø

REMARKS — *Code drugs with numbers, events with letters*

0845 Pt id'd Chart reviewed Provided IV patient
0900 OR #2 O2 monitors
0906 Induction + LMA placement 5 wiggles
0955 LMA #4 Removed. TO PACU

PHYS STATUS: 1 (2) 3 4 5 E

TIME → x 30 x 1000

BODY WEIGHT: ≈ 60 KG

HEMATOCRIT: 14.6/44

INITIAL DATA: BP- 105/51; HR- 66 100%

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? 0905 TIME- 400

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

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

VENTIL

VT - ml	+	300	350	350	600
f - breaths/min	+	10	12	12	12
Peak Inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)	S	AV	SV	SV	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)		50	50	50	45
BP/oth	✓ FIO2 (Frac or %)	e70	70	70	70	70
ART line	✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ ECG II	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	Not available				
	N-M Block (T/4)					
Warming blkt	Room warmed →					
Conv warmer	O2 supine →			O2 TO PACU		

Mark with letters & symbols, explain under REMARKS — EVENTS Position → O2 above

RECOVERY AT 1005 — (PACU) ICU ____ (Specify)

OTHER 1005 [redacted]

CONDITION stable

RESP- 12 SpO2- 100% RA

BP- 111/66 HR- 60

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0845	0900	1005
	Ready	Begin	End
PROC	0906	0930	0954

PROCEDURES and CPT Codes: I+D R) middle finger

ANESTHETIC TECHNIQUES: *Describe block, technique under Remarks* — General (b)(6)-L

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

[redacted]

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Easy mask ventilation. LMA #4 eyes taped closed soft guaze bite guard BBS=CT+ Ⓒ 9am

SURGEONS: [redacted]

[redacted] CRNA

PROCEDURE LOCATION: OR 2

DATE: 23 Nov 03

PAGE I OF I

Preop

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

1205 18; 14.6 / 44.6 418; 132 | 95 | 16 / 4.4 | 29 | 1.1 < 105; 23 y/o ♂ ØPMH NKDA ⊕ TOB - social; 113/43 97.7 P58 R14 98%

NPO since MN

MEDCOM - 24914

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	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	18 NOV 03	2025 HOURS	
1	admit to ICW-1		
2	Dx: UPE [illegible] (R) HEMO		
3	Cardiac - BLR		
4	VS - monitor		
5	IV - Hep lock		
6	UP as LIB PER EIPW, monitor		

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
24°	0035	19NOV03 [redacted]

↓	DATE OF ORDER	TIME OF ORDER	
7	NPO after midnight [illegible] HOURS	DIR. IN AM	
8	Tylenol 650 mg PO Q4 PRN		
9	MSO4 2-6 mg IVP Q2hr PRN		
10	Percocet 1-2 PO Q4 PRN		
11	BP, LBT, ABG/VS (R) HEMO [redacted]		

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	
	19 NOV 03	1245 HOURS	
1	Resume previous orders		
2	Hep lock IV when tolerating PO well		
3	Regular diet		
4	Cheef 7 gm IVPB Q 8 hrs		
5	Ciprofloxacin 400 mg IVPB Q 12 hrs		

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

Hold until 19NOV03 1630

NURSING UNIT	ROOM NO.	BED NO.

↓	DATE OF ORDER	TIME OF ORDER	
6	NPO after midnight HOURS 20 NOV for OR 21 NOV.		
7	WET TO DRY DRESSINGS with [redacted] SOLUTION BID (R) HEMO [redacted]		

NURSING UNIT	ROOM NO.	BED NO.
24°	20 NOV	C

0200 [redacted] 2 [illegible]

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]

Noted [redacted] 19NOV03 75R

(b)(6)-7

NURSING UNIT | BED NO.

DATE OF ORDER: 15NOV03 TIME OF ORDER: 1721 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Renew all previous order

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION: 240 V 20 Nov e 0200 [redacted]

Noted 20NOV03 2145 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

240 V 21NOV03 0445 [redacted]

DATE OF ORDER [redacted] TIME OF ORDER [redacted] HOURS

20 NOV03 2145

(1) NPO P MN to OR NOV 21

V.O [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

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
[redacted] (b)(6)-4			2 NOV 03	1341 HOURS	
Noted 22 NOV 03 [redacted]			(1) Resume previous orders		
			(2) Regular diet		
			(3) Keep lock IV when taking P.O. well.		
NURSING UNIT		BED NO.	(4) NPO after midnight 22 NOV 03 for OR 23 NOV 03		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
24°V @ 0200 none			(b)(6)-2 24 NOV 2003	[redacted]	
			Decrease Pred Acetate to 3 gtt		
			[redacted]		
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]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 23 NOV 03 TIME OF ORDER: 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. Page Dr. [illegible] when taking PO, meds
4. D/c Ciprofloxacin
5. D/c Ancef

PATIENT IDENTIFICATION: [redacted]

NOTED 23 NOV 03 @ 1335 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

6. Levofloxacin 500 mg IVPB Q day
7. Imipenem 500 mg Q 6 hrs (Primaxin IV)

(b)(6)-2 [redacted]

NURSING UNIT: 24° V | ROOM NO.: 24 NOV | BED NO.: @ 0200 [redacted]

PATIENT IDENTIFICATION: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11/24/03 TIME OF ORDER: 0900 HOURS

PRED ACETATE 1% 1 GTTS OD QI° WHILE AWAKE

MAXITROL OINT APPLY OD QHS

06, 12, 18, 24 — CLOXN 1 GTTS OD QID

[redacted]

NURSING UNIT: NW | ROOM NO.: 2 | BED NO.: F 24° V 26 NOV 03 0255 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

(b)(6)-4

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
[redacted]				11/24/03	1526 HOURS	
				DOXYCYCLINE 100MG po qD		
				[redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]				11/25/03	1600 HOURS	
				(1) D dressing changes to (Q) days.		
				(b)(6)-2		11/25/03
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		1625
24° V 26 NOV 03		[redacted]				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]				4 DEC 03	0928 HOURS	
				(1) DISCHARGE TO PRISON CAMP TODAY		
				(2) KEFLEX 250 mg P.O. Q.6.h. 10 days		
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
[redacted]					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

[redacted]

(b)(6)-5

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: 1730
Allergies: NKDA
Pre-op V/S: 113/60 70's
Procedures: I+D deep gluteal abscess

Anesthesia Type (Circle): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 200 Colloid
OR Output: UOP EBL 100cc
Meds/Times:

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

Pre Op Meds History

Time	1730	1735	1745	1755	1800
SaO2	100	99	99	98	100
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120	V	V	V	V	V
100					
80	•	•	•	•	•
60	A	A	A	A	A
40					
20					
RR	18	18	20	20	
T					

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
1730	LR	500	Arm	mg	

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	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.	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

PREPARED [redacted] (b)(6)-7 CPn

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 19 Nov 03

PATIENT'S IDENTIFICATION [redacted] give: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted]

(b)(6)-7

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

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: 1250
Allergies: NKDA
Pre-op V/S: 135/55 clear
Procedures: HD R Hand

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 700 Colloid —
OR Output: UOP — EBL —
Meds/Times: Fentanyl

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1250	1255	1300	1315	1320
SaO2	99	98	95	97	99
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120	✓	✓	✓	✓	✓
100					
80					
60					
40					
20					
RR	10	10	12	10	
T	95				

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
1250	LR	~~700~~ 300	L AC	DR	700

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
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.	8	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 & Ti[redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 19 NOV 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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) hand	WNL	+	+	3-B	W	Pk
15'							
30'							
45'							
60'							
90'							
D/C							

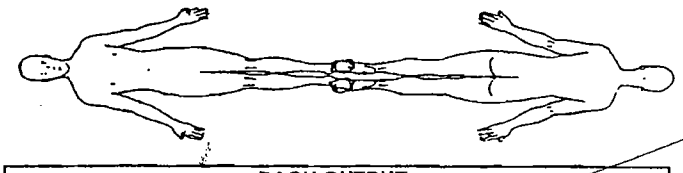
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) hand	Kling	~~0~~
30'		Ace	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1230	SR	~~0~~	~~0~~

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR s/p I&D (R) hand. Kling c/d wrap to (R) hand. IV of LR running into (L) AC. SS to c/o @ 4 hrs time [redacted]

(b)(6)-2

Discharge Criteria:
Date: 19 Nov 03 **Time:** 1330 **PARS:** 9
BP: 116/61 **T:** 96.2 **HR:** 53 **RR:** 10 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: 100 **Output:** ~~0~~
Additional Data:
Transferred To: (CW)
Report Given To: (CW)
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature [redacted] 9 /2

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

OTSG APPROVED *(Date)*

Date: 11/21/03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1340

Allergies: NKA OR Intake: Crystalloid 150 cc Colloid

Pre-op V/S: 114 73 98% OR Output: UOP EBL < 5cc

Procedures: B/O Knee Meds/Times: MCG FENTANYL

B/O ELBOW

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1340	1345	1350	1400	1410											
SaO2	100	99	100	99	100											
FiO2																
Methods	RA	RA	RA	RA	RA											
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR	13	14	12	12												
T	97															

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1340	LR	500	CA	TW	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	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

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

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

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

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

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC PACU

DATE 11/21/03

PATIENT'S IDENT[redacted] *(Typed or written entries give: first, middle; grad[redacted] hospital or medical facility)* *Name – last,*

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

USAPPC V2.00

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
1340							
Adm	(R) Hand	+	+	P	B	W	PK
15'	(R) Hand	+	+	P	B	W	PK
30'							
45'	(R) Hand	+	+	P	B	W	PK
60'	(R) Hand	+	+	P	B	W	PK
90'	(R) Hand	+	+	P	B	W	PK
D/C	(R) Hand	+	+	P	B	W	PK

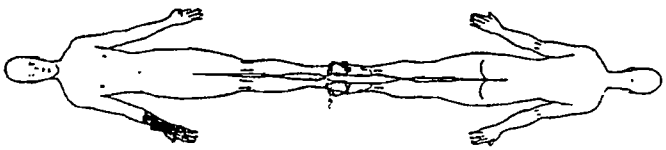
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1340	(R) Hand	ace + kwiker	+
30'	(R) Hand	ace + kwiker	+
60'	(R) Hand	ace + kwiker	+
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
	NONE		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1340	S, S, +	NO	

WAMC OP 173-E

NURSING NOTES

1340 Pt admitted to unit on stretcher from O.R. Pt awakening from sedation. Pt V/S monitored O2 - 100% RA. O/V has BSC & (R) hand ace + kwiker dressing. No sign of bleeding. Pt able to rest quietly after being aroused by physical stimulus. Pt has clear lungs (breath sounds) abdomen: bowel sounds present. Pt has IV in (L) arm and able to move all extremities.
1400. Pt able to voice concerns, Pt able to call family and ask for food.
1420. Pt alert and oriented x 3. able to move extremities. Pt V/S stable and DSC dry. Report given to TCWI - SPC [redacted]

(b)(6)-2

Discharge Criteria:
Date: 11/24/03 Time: 14:25 PARS: 10
BP: 124/71 T: HR: 55 RR: 12 Sa02: 100%
Pain Level at D/C (0-10):
Intake: 100 cc Po Output: 0
Additional Data:
Transferred To: TCWI
Report Given To: SPC [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted]
Cleared IAW Recovery [redacted]
Charge Nurse Signature: [redacted] LT AN

(b)(6)-2

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

83y/o male

OTSG APPROVED *(Date)*

Date: 2 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1010

Allergies: NKDA OR Intake: Crystalloid 500 Colloid

Pre-op V/S: 113/43 58 OR Output: UOP 0 EBL MIN

Procedures: I+D R Middle Finger Meds/Times: Propofol, Lidocaine, Fent, MSO4

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

Pre Op Meds History

Time	1010	1015	1020	1025	1030
SaO2	100	100	97	99	100
FiO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	11	11	10	10	10
T	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

(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	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.	10	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

PRE[redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC PACU

DATE 23NOV03

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

[redacted]

(b)(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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 fing	limited	+	P	B	Wm	PK
15'	R fing	limited	+	P	B	WM	PK
30'	R fing	limited	+	P	B	WM	PK
45'							
60'							
90'							
D/C	R fing	limited	+	D	B	Wm	PK

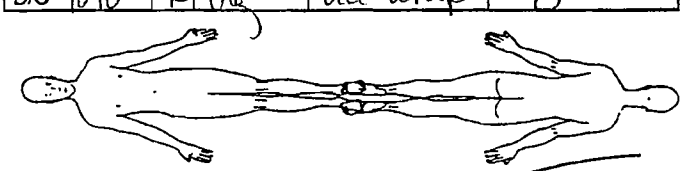
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm ~~R Hand~~ 1014	R fin	ace wrap	0
30' 1040	R fing	ace wrap	0
60'			
D/C 1040	R fing	ace wrap	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1014	NSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received from OR S/p MD (R) middle finger. Pt SpO2 99-100% RA, no c/o pain. Pt being transferred to ICW 1. Report given to Lt Gershmeyer. VSS, no c/o pain. SpO2 99%. Sgt [redacted] LPN

(b)(6)-2

Discharge Criteria:
Date: 23NOV03 Time: 1040 PARS: 10
BP: 109/57 T: 97.2 HR: 60 RR: 12 Sa02: 98%
Pain Level at D/C (0-10):
Intake: — Output: —
Additional Data: —
Transferred To: ICW 1
Report Given To: Lt [redacted]
Transferred Via: W/C [redacted] Ambulance
Transferred By: Sgt [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

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 18	19	20	21	22	23	24	25	26	27	28	29	30
18	[redacted]	VS: routine	6	[redacted]												
			18													
18	[redacted]	Up ad lib per EPW	6													
		protocol	18													
19 NOV	[redacted]	Regular diet	6 12 18 00													
19	[redacted]	WTD dsg c Betadine	10													
		soln BID @ hand	22													
11/25	[redacted]	Δ dsg Δ to Q day	10													
	[redacted]	WTD dsg c Betadine	10													
		Soln (R) hand)														
11/30	[redacted]	Enc pt to Δ position	6													
		Q2° to prevent skin	18													
		breakdown	/													
11/30	[redacted]	Check skin integrity	6													
		& document QS.	18													

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: infected (R) hand

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-7

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10	[redacted]	Tylenol 650mg po Q4° prn	D/T	19 NOV 2035												
			D/I	[redacted]												
18	[redacted]	MSO4 2-6mg IVP Q2° prn	D/T	[redacted]												
		(5)(6)=2	D/I	[redacted]												
10	[redacted]	Percocet 1-2po Q4° prn	D/T	19 NOV 1052	20 NOV 0840	20 NOV 1645	21 NOV 1100	22 NOV 1605	23 NOV 1748	24 NOV 1245	26 NOV 0985	26 1930	26 2330	27 1115	27 1930	27 NOV
			D/I	[redacted]												
18	[redacted]	Percocet 1-2po Q4°	D/T	20 NOV 1430												
			D/I	[redacted]												
		[redacted]														

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

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
18	[redacted]	Admit ICW#1, condition: fair				
18	[redacted]	NPO p̄ MN for OR in Am	11/18 / 11/19	2359 / AM		
18	[redacted]	XRays done in ER.	done	—		
19 NOV	[redacted]	Resume previous orders	19	—		[redacted]
19	[redacted]	NPO p̄ MN 20 NOV for OR 21 NOV	21 NOV	0001		
19	[redacted]	Resume all previous orders	19	—		[redacted]
21	[redacted]	Resume previous orders	21	1341		[redacted]
21	[redacted]	NPO p̄ MN 22 Nov 03 for OR on 23 Nov 03	23	0001		[redacted]

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
----	----															
----	----															
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----	----															
----	----															
----	----															
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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 1	02	03	04									
18 Nov	[redacted]	VS Routine	06	[redacted]												
			18													
18 Nov	[redacted]	Up ad Lib per EPW	06													
		protocol	18													
19 Nov	[redacted]	Regular diet	06													
			18													
25 Nov	[redacted]	Δ Dsg changes to	10													
		QD W/D & Dakins	X				DCd 02 DEC 03									
		Soln. (R) HAND	X													
30 Nov	[redacted]	Enc. Pt to Δ	06	[redacted]												
N/O		position Q2°	18													
		to prevent skin														
		breakdown														
30 Nov	[redacted]	Check skin integrity	06	[redacted]												
N/O		document Q shift	18													
		(b)(6)-2														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Infected (R) hand / OD Corneal staining

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

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							

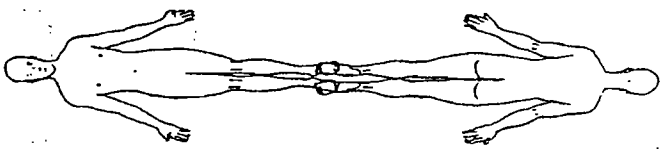
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Male Iraqi admitted to PACU S/P IAD (b) check wound c̄ Artery Ligation SPO2 100% RA NO s/s respiratory distress VSS Wound to check intact NO drainage noted DSB to (b) arm CDI. will continue to monitor [redacted] SSG/CPN

(b)(6)-2

Discharge Criteria:
Date: 19 Nov 03 **Time:** 1100 **PARS:** 9
BP: 110/56 **T:** **HR:** 77 **RR:** 20 **SaO2:** 100%
Pain Level at D/C (0-10):
Intake: L100 **Output:** Ø
Additional Data:
Transferred To: ICW 1
Report Given To: ICU [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: SSG [redacted]
Cleared IAW Recovery Ro[redacted]B-3
Charge Nurse Signature:

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. Dec Yr. 02

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4
18 NOV	[redacted]	H L IV when	06	[redacted]			
	-----	Tol. P.O well	18	[redacted]			
23 NOV	[redacted]	Levofloxacin	08	[redacted]			
	-----	500mg IVPB QD	X				
23 NOV	[redacted]	Primaxin 500mg IVPB	06	[redacted]			
	-----	Q6°	12	[redacted]			
	-----		18	[redacted]			
	-----		24	[redacted]			
24 NOV	[redacted]	Maxitol Ointment	22	[redacted]			
	-----	apply QD QHS	X				
24 NOV	[redacted]	Ciloxin ¼ gtt OD	06	[redacted]			
	-----	QID	12	[redacted]			
	-----		18	[redacted]			
	-----		24	[redacted]			
24 NOV	[redacted]	Doxycycline 100mg	08	[redacted]			
	-----	P.O QD	X				

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

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Infected (R) hand / OD corneal ulcer

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

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 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
18	[redacted]	MSO4 2.6mg q 2° IV pm	D/T	4DC 0910											
			D/T	[redacted]											
18	[redacted]	Percocet II PO q4° pm	D/T	4DC 0910											
			D/T	[redacted]											
		(5)(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 24	25	26	27	28	29	30	1	2	3	4	5
11/24	[redacted]	Pred Acetate 1%	01	[redacted]											
	[redacted]	1/2 Gtts OD Q1° while	02												
	-----	Awake	03												
	-----		04												
	-----		05												
	-----		06												
	-----		07												
	-----		08												
	-----	(b)(6)-2	09												
	-----		10												
	-----		11												
	-----		12												
	-----		13												
	-----		14												
	-----		15												
	-----		16												
	-----		17												
	-----		18												
	-----		19												
	-----		20												
	-----		21												
	-----		22												
	-----		23												
	-----		24												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Infected (R) hand

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

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 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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. 83

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25	26	27	28	29	30
18/19	[redacted]	IV: HL when tol. PO	6	[redacted]												
	-----	well	18	[redacted]												
19 NOV	[redacted]	Ceft 1 gram IVPB	06	/	/	[redacted]										
	-----	q8°	14	/	[redacted]						D/C'd 23 NOV 1300					
	-----		22	/	[redacted]											
19	[redacted]	Ciprofloxacin 400mg	08	/	/	[redacted]										
	-----	IVPB q12°	20	/	[redacted]						D/C'd 23 NOV @1300					

23	[redacted]	LEVOFLOXACIN 500mg	08	/	/	/	/	/	/	[redacted]						
	-----	IVPB QD		/	/	/	/	/	/							
23	[redacted]	PRIMAXIN 500mg IVPB	06	/	/	/	/	/	/	[redacted]						
	-----	Q6°	12	/	/	/	/	/	/							
	-----		18	/	/	/	/	/	/							
	-----		24	/	/	/	/	/	/							
11/24	[redacted]	Fred Acetate														
	-----	1 gtts OD Q1° while														
	-----	Awake.														
11/24	[redacted]	Maxitol ointment	22						/	[redacted]						
	[redacted]	apply OD QHS														
11/24	[redacted]	Flexin 1 gtts	06							[redacted]						
	[redacted]	OD QID	12						/							
	-----		18						/							
	-----		24						/							
11/24	[redacted]	Doxycycline 100mg	08						/	[redacted]						
	-----	PO QD														

	-----															

(5)(b)-2

(5)(b)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: infected (R) hand

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

[redacted] (5)(b)-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 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 24935

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted]	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1982-01-01	21Y	X (b)(6)-4	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:
		17:15	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee
(b)(2)-2 Name and Location of Medical Treatment Facility: [redacted]aq; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-12-04

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
AEA - ORTHOPEDICS		2003-11-18

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-11-18

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: INFECTED R HAND/OD CORNEAL STRING

Procedure Narrative(s):

Cause of Injury Narrative:

Dx 9583
9039
9213
E993
Proc 8604 x3
3952
Trauma 9
Inj 599 [redacted]

(b)(6)-2

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted]	for [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Lo. IZ			
3. Register Number [redacted]	Name (Last, First, MI) (5)(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1982-01-01	7. Age at Admission 21Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 17:15	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
(5)(6)-2 Name and Location of Medical Treatment Facility: [redacted] all Provided		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-12-04		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-18		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-18		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: INFECTED R HAND/OD CORNEAL STRING

Procedure Narrative(s):

Cause of Injury Narrative:

Dx 9583
9039
9213
E993
Proc 8604 x3
3952
Trauma 9
Inj 599 [redacted]

(6)(6)-2

Admitting Officer (Signature, as required) [redacted]	Signature of Admitting Clerk for [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 24937

pr# 1351

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

[X] Offense against Civilian(s) [check one] If "Other" then describe: SET OFF EXPLOSIVE IN HOUSE

- [ ] Arson (I.P.C. 340)
- [ ] Solicitation of Fornication/Prostitution (I.P.C. 399)
- [ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- [ ] Murder (I.P.C. 405)
- [ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- [ ] Maiming (I.P.C. 412)
- [ ] Simple Assaut (I.P.C. 415)
- [ ] Kidnapping (I.P.C. 421)
- [ ] Burglary or Housebreaking (I.P.C. 428)
- [ ] Extortion/Communicating Threats (I.P.C. 430)
- [ ] Theft (I.P.C. 439)
- [ ] Destruction of Property (I.P.C. 477)
- [ ] Obstructing a Public Highway/Place (I.P.C. 487)
- [X] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- [ ] Riot or Breach of Peace (I.P.C. 495(3))
- [ ] Other

[X] Offense against Coalition Forces [check one] If "Other" then describe: POSSESSED ILLEGAL EXPLOSIVE

- [ ] Violation of Curfew
- [X] Illegal Possession of Weapon
- [ ] Assault/Attack on Coalition Forces
- [ ] Theft of Coalition Force Property
- [ ] Trespass on Military Installation or Facility
- [ ] Photographing/Surveiling Military Installation or Facility
- [ ] Obstructing Performance of Military Mission
- [ ] Other

Apprehending Unit:		Location Grid:	
Date of Incident (D/M/Y) 13/NOV/03 to / /	Time of Incident: hrs to hrs	Date of Report (D/M/Y) / /	Time of Report: hrs

Detainee # [redacted]		Key Connected Person: [ ] Victim [ ] Witness	
Last Name: [redacted] (b)(6)-7		Last Name:	
First Name [redacted]	Given Name [redacted]	First Name:	Given Name:
Hair Color:	Scars/Tattoos/Deformities:	Hair Color:	Scars/Tattoos/Deformities
Eye-Color:	Weight: lb / Height: in	Eye-Color	Weight: lb / Height: in
Address:		Address:	
Place of Birth:		Place of Birth:	
Ethn/Tribe/Sect	Sex: [X] M [ ] F / Phone#: DOB D/M/Y / [ ] Mobile [ ] Regular	Ethn/Tribe/Sect	Sex: [ ] M [ ] F / Phone#: DOB D/M/Y / [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr license [ ] Other (specify) Document #:		[ ] Passport [ ] Dr license [ ] Other (specify) Document #:	

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information	Vehicle Number ____ of ____ Vehicle(s)	Owner:	
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband	[ ] Weapon	Photo Taken of Suspect with Weapon/Contraband: Yes/ No	
Type	Model:	Color/Caliber	
Serial No.	Quantity	Make:	Receipt Provided to Owner: Yes/ No
Other Details	Where Found	Owner	

Name of Assisting Interpreter:	Email, Phone, or Contact Info.

Detaining Soldier's Name (Print):	Supervising ~~Officer's~~ Name (Print): SFC [redacted]
Last, First MI	[redacted] Last, First MI
Signature:	Signature: [redacted] (b)(6)-7
Email:	Email: [redacted] SMIL.MIL
Unit Phone: Date / /	Unit Phone: [redacted] 551-91 Date: 18 NOV 03

ALT. POC, CPT [redacted]

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? FOR SETTING OFF EXPLOSIVE IN RESIDENCE

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying? EXPLOSIVES

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: PERSON HAS BEEN MEDEVACED FROM DIVISION INTERROGATION FACILITY - MEDICAL FACILITY BIAP WEST HAD ADMITTED SUBJECT AND ORDERED HIS TRANSFER.

Automated Facsimile

IN. .TIENT 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]FirstNameGiven					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]	(b)(6)-4				ICU3	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	23:50	ABA - GENERAL SURGERY					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-OTH	2003-12-02					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-11-18	[redacted]				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
[redacted] (b)(2)-2		2003-11-18					

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW SHRAPNAL CHEST

880.01
810.10
453.8
E922.9

83.82
86.28

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	14	14

35. Total Days This Facility (b)(6)-2

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	14	14

Signature of Attending Medical Office[redacted]

Automated Facsimile - DA FORM 3647, [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Iraqi EPW involved in shooting + suffered GSW to upper (L) back/chest - Bullet appears to have entered back near scapula, traversed through the chest and exited anterior chest wall. Pt arrived (@) FST c̄ 2 chest tubes in place. These were replaced and pt given 2 units blood & sent to [redacted] (b)(2)-2

PMHx: unknown PSHx: unknown Meds: unknown All: unknown

PHYSICAL EXAMINATION

Intubated VS - 114/71 P-100 R-14 Sats-93% @

HEENT - NC/AT

NECK - Sub Q air

Chest - ant chest wall wound c̄ bone exposed (clavicle) communicating with chest cavity

CXR - contusion LUE
CT in place

CT - Sub Q air
Contusion LUE c̄ bronchogram
CT in place
Fx clavicle

results appear intact

CVS - Reg

abd - Benign

Ext - bounding pulse LUE

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

Dx: GSW to chest

Plan: OR for debridement/acute flap closure

ancef

(b)(6)-2

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
GSAPPC 71 00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 Nov	BRIEF OP NOTE
0245	Preop: GSW to back / chest - open chest wound
	Postop: Same
	Procedure: ~~Wound~~ Anterior chest wall wound exploration / debridement
	PARTIAL PECTORALIS MUSCLE FLAP to cover wound
	Surgeon: [redacted]
	Anest: GETA
	EBL: 100 cc
	IVF: 1300cc crystalloid
	UO: 1000 cc (b)(6)-2
	Findings: Open anterior chest wall wound
	ĉ air leak, Subclavian vein / artery intact.
	Drains: - 2 chest tubes
	- #10 JP over pectoralis flap
	Complications: None
	Disposition: to ICU stable
	[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Transfer Summary

Admitted 11/29 OR 11/19

Pt is EPW who suffered GSW to (L) chest/shoulder. Was taken to FST where 2 chest tubes placed. Sent to 28th for further management p̄ getting 2 units PRBC + being intubated.

In ER pt was stable. He was noted to have a GSW entrance near (L) scapula + exit over (L) ant sup chest near shoulder. (+) Scapula/clavicle fracture. Good pulse (L) hand.

Pt taken to OR where wound debrided and partial pectoralis muscle flap used to close pleural defect. Subclavian artery and vein intact. Wound closed over JP. Pt extubated POD #2. Pt on POD #3 noted to have LUE swelling + ultrasound showed (L) subclavian thrombosis - Started on heparin + Coumadin JP's + CT's removed

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	on POD #5 s complication. Pt improved with weaning of oxygen after ↑ mobilization
	on POD #11 noted to have marked ↓ swelling of LUE.
	plan: Remove sutures POD #21 Coumadin 3mg PO QD x 3 months pain control NWB to RUE x 6 weeks
	[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 NOV 03	0245 - pt arrived fm OR via bed. Hooked up to monitors. Temp 92.4 chief cuddler applied rectal temp probe in place. all other VSS. Sedation/pain mgmnt started. Cont. to monitor. [redacted] UTAN
19 Nov 03 2000	Pt placed from chair back to bed x 3 hours sitting up. UOP @ 2000 ↓34cc, charge nurse notified & will call SOD @ 2100 if UOP cont. to ↓ Systolic BP from 85-97 & MAP between 62-69, pulses 86-98. Cont. to monitor. [redacted] 91WSM6
19 Nov 03 2100	Pt UOP ↓32cc & Dr Matsumoto @ bedside, stated if UOP ↓ below 30cc/hr then give pt a 500cc NS bolus. Aware also of SBP & MAP of pt, will cont. to monitor. [redacted] 91WSM6
20 Nov 03	Pt SaO2 ↓ 93% while pt sleeping this hour, awaken & made to do incentive spirometer & O2 @ 4L via NC. SaO2 96% @ this time & will cont. to monitor. [redacted] 91WSM6
20 Nov 03	Report given to oncoming shift, pt up to chair @ 0540. SaO2 between 95%-98% on 4L O2 via NC. [redacted] 91WSM6
20 Nov 03	Assumed pt care @ 0000, pt up to chair, CT x2, JP x1, NC 6L O2, Ø 5/5 O2 dressing, MSO4 @ 1.2mg/hr, Ø 5.5 NS & 20KCL @ 100, Report given by SGT [redacted] [redacted] LPN/RN

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

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 NOV 3	PT c̄ H/H of 9.4/28.7, two PRBC ordered for transfusion; 2 units transfused as follows:

Unit #1 = WO20403002465 started @ 0730

pre-transfusion HR 95, BP 110/73 RR 29 97% Temp 97.4

	0735	0740	0745	0800	0815	0830	0845	0920
HR	98	99	90	91	101	99	100	90
BP	100/67	104/69	103/62	103/64	117/70	104/67	109/64	114/70
RR	27	28	25	24	27	28	25	24
O2	96%	95%	94	97	98	99	99	100%
Temp	97.2	97.0	97.4	97.2	97.2	97.4	97.4	97.4

finished @ 0920

Unit #2 = 5307160 started @ 0940

pre-transfusion HR 99, BP 115/87, RR 25, 100%, Temp 98.3

~~HR~~	0945	0950	1005	1020	1035	1050	1110
~~BP~~ HR	97	93	87	94	100	95	98
BP	114/70	116/67	110/69	117/75	135/76	110/65	108/70
RR	25	24	24	24	22	20	25
O2	98	99	99	96	94	94	95
Temp	97.6						98.4

finished @ 1110 [redacted]

20 NOV 3 PT on Ry Diet tolerating well, PT ready ambulate TO ox 1/5, PT DID fairly well all day long, denies stabbing right pain TO SST [redacted] LG/SC

(b)(6)-2

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	Surgery
20 NOV 03	
0850	Pt stable c/o chest pain @ wound site.
	Breathing well
	AUSS
	CT - 270/30 JP - 30 NO air leak
	Chest - dressing intact, ronchi in upper lobe
	CVS - Reg
	Abd - soft NT/ND (+) BS
	Ext (-) C/C/E
	HCT - 26 this AM
	CXR - (P)
	Pro: S/P GSW to chest s/p flap repair
	Plan: f/u CXR
	transfuse 2 units PRBC
	Cont O_2/ Monitor/CT for 24 - 48 hrs more
	[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. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Nov 03 2100	Pt tolerated a very small portion of his regular dinner tray. Pt O2 ↓ to 4L to maintain SaO2 > 96%, will attempt to wean O2 ↓ throughout this shift. Cont to monitor. [redacted]
21 Nov 03 0105	Pt breathing shallow c̄ beads of sweat on his ~~etc~~ forehead c/o pain in his upper chest. Given 1mg bolus of MSO4 & ↑ to 2.0mg/hr, RN notified; Will cont to monitor. [redacted]
21 Nov 03 0615	Report given to oncoming shift. @ approx 0520 pts SaO2 ↓ 91% on 5L NC when trying to get the pt up to a chair the pts SaO2 ↓ 79%. Pt placed on 10L NR, SaO2 98%, & pt left in bed & HOB raised. [redacted]
21 Nov 03 0930	Received report from previous shift. At beginning of shift pt lying in bed. Pt now out of bed to chair. VSS! CTX2 in place. Pt continues to use the incentive spirometer as ordered. Will continue to monitor. [redacted]
21 Nov 03 1210	Pt back to bed. O2 sats ↓ to 80's. Increased O2 to 6L via N/C. O2 sat's back up to 93-95%. Will continue to monitor. [redacted]
21 Nov 03 1220	Pt coughing up blood tinged sputum. Will continue to monitor & assess. [redacted]
22 Nov 03 0600	Pt had an uneventful night, VSS, SaO2 > 94% on 3L O2 via NC throughout this shift. Pt up to chair @ 0530, report given to oncoming shift. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22 NOV 03	Surgery
0930	Pt improving slowly
	AVSS Sats - 95-100% on FL
	CT ~220 cc JP ~15-20cc
	chest - nonlin (+) chest
	wound CIDE
	skin - (+) on gauzes (+) chest on US.
	PTT - 26 on 700 units heparin
	Plan: D/C JP
	↑ heparin
	will start Coumadin once CT out
	(b)(6)-2 [redacted]
22 NOV 03	Assumed pt care @ 0600, ~~Pt Pain~~ Pt OOB TO chair, PT ~~[illegible]~~ Denies any Pain or discomfort, ~~Pt~~ CT x1 TO suction, JP x1 TO suction, Pt on Heparin Drip @ 14cc/hr. PT in stable condition, AVSS, some edema LUE left from due to thrombosis, NO BP, needs stick DO Sc and a this am. work cont. to monitor [redacted] /CT for

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Nov 3	PT/PTT & CBC DRAWN @ 0806, PT/PTT 12.9/24.4, Heparin drip increased to 1000 units/hr from 700; PTT to be done @ 4 Hrs (@ 1400). PT resting presented and well, NO N/V/D, eat about 25% of breakfast — [redacted]
22 Nov 03	PT DID well all day long, mouth, skin, Foley, BLE & bom [illegible] Dropped @ 1530 pt reported it well, PT ate < 25% of dinner, Ensure suggested to nutritionist, PT's condition remains the same, resting in bed, during chart Dr NO S/S of infection, NO S/S of bleeding, Repeat gain to Spec [redacted]
22 Nov 03	4 mg MSO4 bolus given for pain [redacted] T/M
21 Nov 03 1800	Assumed PT care @ 1900 assess not on flow sheet, PT not eating dinner will continue to encourage (L) arm very edematous is elevated Radial pulse is difficult to assess cap refill slow (3 sec), Lue very painful pt given MSO4 bolus (4mg) in addition to 2 mg/drip: PT now resting in NAD will cont. to monitor — SPC [redacted]
1930	PT ate only 25% of usable food dinner did not touch rest of plate — SPC [redacted]
2100 ~~2000~~ JR	PT. coughed up med amount of thick blood tinged sputum resting comfortable, now in NAD O2 sat @ 98% — SPC [redacted]
2300	USS PT sleeping in no acute distress — SP [redacted]
2400	water level in CT filled back to 20cm mark — SP [redacted]
0100	PT complained of pain in upper chest given 2 mg MSO4 given PT now resting comfortably — SPC [redacted]
0200	PT repositioned because of pain pulse & cap refill checked in (L) arm — SP [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0410	LABS drawn taken downstairs PT coughed up small amount of thick bloody mucus. —— SPC [redacted]
0410	PT complaining of pain @ Foley site no redness or S/S of infection present, PT has large bruise [redacted] along (R) outer aspect mid axillary line. bruise is dark purple and soft will continue to monitor —— SPC [redacted]
0600	Report given to next shift —— SPC [redacted]
0600	PT alert and oriented x 3. Supplemental O2 2L via NC being given. PT tolerating O2 sat of 98%. Chest tube intact on (R) side of chest. Bleeder vac bubbling. Foley to gravity - light yellow urine evident in line. PT has FEM line in (R) foot and PEG line in (R) femoral area - PT has clear upper breath sounds and diminished breath sounds in lower lobes. S1 S2 present. Suture line upper (R) side of chest intact - no drainage. (R) arm edematous and sensitive to movement - strong pain. Bowel sounds present, radial, pedal pulses strong and regular. PT able to move all extremities and torso in bed for proper body alignment. HOB elevated at 35° and PT absorbed 25cc of juice. Witnessing PT to cough and deep breathe [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11/23/03 10 AM	Pt IV flow increased to 24 cc/hr. at 1200 u/hr. Pt encouraged to use spirometer & deep breathe and use arms and legs for body alignment. [redacted]
1200	Pt is stable, with minimal pressure/treatment. Pt able to take small sips and voices concerns in regards to repositioning and comfort. (R) arm elevated to assist in reducing of edema. [redacted]
1400	Pt moved out of bed to chair. Pt tolerate transfer well. Encouraged to take deep breaths. Skin evaluation done — [redacted]
1600	Pt weighed to 80.1 lbs seen by MD on rounds, CT DIC & gravity — V/S stable except for Pt dependence on 2L O2 to set at 96-100% [redacted]
1800	Pt complained of pain discomfort in upper (R) region morphine drip increased to 4 mg/HR. Pt complained of foley discomfort - foley patent - adequate amount of yellow urine per HR. Foley patent - urinary bladder flat. Pt able to relax quickly and maintain V/S [redacted]
1830	Pt (L) arm shows sign of decreasing - pulse present radial and arm elevation maintained. Report given to CPO [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 NOV 03 1830	Alert x3 - USS - IV of D5NS @ 20K @ rate in (D) forearm A-line is patent, heparin gtt to (D) leg @ 1200 u/hr patent. MSO4 4mg/hr fentanyl continuous CT to (D) side chest to h2o seal drainage dark red drainage. foley to gravity drainage clear yellow urine 150ml/hr. sutures to upper (D) chest incision intact. @ drainage site. Bertha 3w HR-NSR SS2 Lungs CTA - LL lobes diminished CT to (D) side. Reg eqn. BS (D) ↓ ↓ cards. Pedal pulses +3 (R) Radial +2 (L) +2 ARM swollen warm to touch CMS intact - capfill ≥ 3 sec. 0 flus Ø c/o @ present HOB ↑ Resting quietly c̄ eyes closed. — [redacted]
23 NOV 03 1140	CT to h2o seal drainage sml dk red blood drainage. MSO4 1UP hr pain control Ø c/o pain or discomfort @ present. Resting quietly c̄ HOB ↑. — [redacted]
24 NOV 03 0200	Resting quietly Ø c/o pain or discomfort. O2 2L/min via NC SpO2 96-97%. (R) Arm remains edematous. Radial pulses +2 warm to touch. — [redacted]
24 NOV 03 0400	Resting quietly c̄ c/o. SpO2 97% O2 on @ 2L/min via NC. HOB ↑. — [redacted]
24 NOV 03 0500	Bed bath and lin change. CT to h2o seal 15ml out dk red drainage. O2 @ 2L/min via NC SpO2 96%. foley to gravity putting out 100-200ml clear yellow urine/hr. Ø c/o @ present. [redacted]

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

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

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

[redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Nov 03	Surgery
0720	Pt stable
	Ausc CT - 250 cc / 24 hr 15 cc last 6
	chest - improved breath sounds (L) side
	CT serous, wound clean mild erythema
	CNS - [redacted] (b)(6)-2
	abd - [redacted]
	Rx: s/p LSW to chest, (L) subclavian vein thrombosis
	Plan: Cont heparin
	If CT output <50 cc over next 8 hours wind d/c
	chest tube this PM + transfer to floor
	(b)(6)-2
	[redacted]

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

DATE	NOTES
24 NOV 03 @	0800 Received pt from night shift in stable condition see I+Os, VSS, and full assessment on ICU flowsheet. Suture line to upper (R) chest OTA, ∅ drainage noted, well approximated edges, ∅ redness or swelling noted. (R) chest area w/ dsgs c/d/i and CT intact and to H2O seal. (L) arm swollen, warm, (B) pulse and brisk cap refill. Pt remains on O2 2L NC for O2 Sats >93%. IWABX cont. (R) femoral cath intact and ∅ S/S of infiltration or infection. (L) PIV to shin intact w/o redness swelling or pain. Tol PO, but poor appetite noted. ∅ complaints c this time. Will cont to monitor. [redacted]
1042	Pt remains w/o complaints c this time. Resting comfortably. ∅ changes to (R) arm. 10cc cl output from chest tube. [redacted]
1319	Pt OOBTC, VSS, ∅ complaints c/c PO intake, pt is drinking ensure c this time [redacted]
1451	At approx 1445 pt vomited x1 appears to be ensure, all pt had consumed was a few ounces of ensure, < 25% of can, a few sips of lemonade provided in jimmy deans lunch and cream of breakfast from jimmy deans. [redacted]
1616	Pt has decreased UO x 2 hours. 2nd hour Foley flushed, returned flush quantity 30cc Foley then d'd. ∅ clog noted. Bladder

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Nov 03 1619 cont	is palpatable, and palpated by two seperate RN's. Informed Dr [redacted] and called MOD x2. No response from MOD. Interpreter called and pt states a burning and difficulty to urinate. States he has past kidney problems. Pt stood up and ↑ flow noted, but still low quantity. Sediment noted ~~early~~ [redacted] earlier this shift, but again no sediment of Foley trip when Foley Δd. Will cont to monitor and contact MD [redacted] 1655. Dr [redacted] notified about ↓ urine output, pt complaint about pain + difficulty and information about past kidney problems. Pt returned to bed also. Dr [redacted] states that he was not concerned about urine @ this time and to pull foley. Foley pulled @ 1657. Dr [redacted] informed that 70cc of fluid out from CT after pt returned to bed. MD stated CT would be pulled tomorrow [redacted]

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RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (SSN or Other) [redacted]
	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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PROGRESS NOTES
Medical Record

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C# [redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1700 24 NOV 03	Assumed PT care @ ~~1900~~. PT Resting in Bed. PT still refusing to eat Foley pulled @ 1700 PT still unable to void. PT told this an interp. that if he does not void w/in 4hrs new foley will have to be started, skin temp. cool L arm leakness improved bowel Urip not @ therapeutic levels. SPC [redacted]
2000	PT drank 1/2 of his dinner still no urine output @ this time will continue to monitor — SPC [redacted]
2200	PT used urinal 275 output. PT also used incentive spirometer. 2200 meds given PT in NAD — SPC [redacted]
2300	PT removed NC SATS ↓ 89 Replaced NC & instructed PT not to remove SATS back TO 98% — SPC [redacted]
2315	PT complained of pain in abdomen bladder is palpable. PT repositioned will continue to monitor — SPC [redacted]
2400	PT OOBTC, On Bedside commode very little brown loose stool. PT also had an episode of emesis. Small amounts of whitish brown liquid & dark brown flecks. PT now laying down will monitor closely — SPC [redacted]
0200	PT complaining of itching in (L) ~~hand~~ arm is now resting comfortably — SPC [redacted]
0330	PT up asking for urinal uss. in NAD — SPC [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

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0530	Pt voided 200 cc urine dark yellow no sediment USS
	in NAD ——— SPC [redacted]
0600	0600 meds given. LABS Lyte PTT still in 30 sec range not therapeutic
	X RAY done by SSG [redacted] ——— S[redacted]
0605	Pt voided 250cc urine via urinal. Pt is now taking
	bed bath. ——— SPC [redacted]
	(b)(6)-2
25 Nov 03	Surgery
0710	Pt stable
	AVSS CT L 150cc/24 hrs serosan
	Chest - Slowly improving aeration
	Wound Erythema d/c
	CVC - fy
	Abd - Benign
	Imp: S/P GSW to chest
	Pln: CT D/C'd this AM
	Transfer to floor
	Start Lovenox
	(b)(6)-2
	[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25NOV03	(1745) Assumed care of pt from ICW3 via gurney in stable cond. VSS. Ø C/O pain. Pt alert, speaking Arabic. O2 via NC @ 4L. SpO2 97-98%. IVFs infusing into IV in @ femoral via dial. a. flow ~ SISX infection/infiltration. Hep drip infusing into 18g IV in @ leg ~ SISX infection/infiltration via dial. a flow @ 24cc/hr. Dsg to @ side of chest CDI. Ø resp. distress noted. Pt voiding ~ difficulty. 2 point restraints in place ~ SISX complications. Will cont. to monitor. [redacted]
25NOV03 (1900)	VSS. Alert & Oriented. O2 @ 4l NC O2 SAT 98% ~ Resp even & unlabored. Lungs clear bilaterally with diminished to LLL. Incentive spirometer used properly @ 600-900cc/sec. E non productive cough. (L) UE swollen but non-pitting. Radial pulses +2 (B) capillary refill brisk. (R) subclavian incision with edges well approximated & sutures intact. Incision without drainage. (R) femoral IV patent & intact infusing. D5 1/2 NS ~ 20mEq KCl/L @ 125cc/hr via pump. (L) Leg IV

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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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (Continued)
25TNOV 03	Patent & Inlet infusing Heparin @ 1200 unit/hr. Pedal pulses +2 Bilaterally. OOB to BR c̄ +1 assist. ~~Hdt~~ Had BM. Consumed 30% of regular diet for dinner. Pt's 30% Percocet effective for pain manag. Will continue care as planned [redacted]
26NOV03 (1945)	Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb to BR s̄ difficulty. OOB to chair for several hours. tol. well. SpO2 97-98% on 4LO2 via NC. ∅ resp. distress noted. Dsg to @ side of chest Δd. ∅ slsx infection @ dd CT sites. Pt tol. sm. amount reg diet. Voiding s̄ difficulty. IV in @ leg dlcd d/t infiltration. leg IV started in @ forearm. Heparin gtts @ 24cc/hr infusing s̄ slsx infiltration. IVFS SLd in cordis in @ femoral. ∅ slsx infection/infiltration. 2 point restraints in place s̄ slsx complication. Swelling noted in LUE compared to RUE. Report given to oncoming shift. [redacted]
26NOV03 (1900)	VSS Alert & Oriented. O2 @ 4L NC. [illegible] 98% Lungs clear c̄ diminished. to (B) LL. Uses Incentive Spirometer @ 600-900 cc/sec c̄ min productive cough. Peripheral pulses palpable +2. (R) femoral IV patent & intact and Hep locked. (R) FA IV patent & intact infusing heparin gtt. Consumed 75%

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[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

(Continued)

26NOV03 of reg diet for dinner. (L) UE ≈ swelling but non pitting. No noted active bleeding. Very clear yellow urine (L) subclavian ~~[illegible]~~ incision ≈ suture edges well approximated. 2 point restraints in place. Will continue care as planned. [redacted] 2CTN

27NOV03 (0900) NSG. VSS. ⊖ c/o pain, sutures to (D) side of chest wall. CDI, well approximated, ⊖ signs of infection. ⊕ DSG to (D) side of chest. ~~Old CT DSG~~ CT DSG from ~~D/C~~ previous CT. DSG CDT. Pt on O_2 4L sat 98%. RA sat 90%. LS sounds coarse through all lung fields. (L) upper lobe rhonchi. Enc. pt to do IS @ 1h to prevent infection in Lungs. Pt verbalized understanding. (L) arm ⊕ 2 edema 2° (L) subclavian thrombocysis. Pt voided blood tinged urine. Notified Gen Surgery on ~~yellow~~ & yellow radio of finding. ~~&~~ Paused heparin drip. No new orders pending. (R) Fem art infusing IV ABX ~~&~~ ≈ difficulty. Pt asleep. Will monitor urine. [redacted] 1900

(1600) Dr [redacted] came to ward. VO coag panel. Asked if to continue Heparin drip. Dr [redacted] ordered to cont[redacted] heparin drip until coag panel back. [redacted] 1700

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

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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
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[redacted]

(b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 NOV 1900	Patient OOB → Chair ≈ O_2 SAT 95-96% on RA. Using chest tube spirometer properly @ 600-900 cc/sec ≈ non productive cough. Voiding tea colored urine per urinal @ this time. PO fluid intake encouraged. Peripheral pulses palpable +2. (L) UE continued to be edematous. Ambulated to BR ≈ assist but supervised. (R) ~~gtt~~ femoral IV patent & intact with active blood noted around insertion site. (R) FA saline lock patent & intact. The active blood noted @ IV insertion site. 2 point restraints in place without compromising circulation or skin integrity. Will continue to monitor closely for active bleeding [redacted]
28 NOV 03	(1020) NSB. VSS. pt c/o pain (L) side of chest. Incision to (L) side of chest well approximated c̄ ⊖ signs of infection. Δ DRB to (R) femoral line c̄ sterile technique. ⊖ signs of infection. Flushes well. ~~Lung sounds~~ (L) upper lobe (+) coarse c̄ rhonchi. Lung sounds (b)(b)2 ↓ in (L) side of chest. Sat 95% RA. (L) arm (+) edema. (+) 2 radial pulses B/L. Enc IS use. Pt demonstrated proper [redacted] use.
29 NOV 03 @ 0015	assumed care of pt @ 1800. VSS, Sats 95% on RA. Pt alert, speaking arabic, LS CTA (R) lobes, (L) lobes ↓ @ bases. Uses IS properly. Approx 2345 ml, rechecked sats: pulse ox 90% on RA. 2 LNC applied c̄ sats ↑ to 96%. (L) chest incision CTA, CDI. (CONT) Inglewood

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
28NOV03 @ 0015	(CONT) old CT insertion site OTA, intact. (+) BS, tol reg diet well, void per urinal QS. (R) fem line Drsg reinforced, flushes easily. (R) FA PIV flushes well, IV Abx cont. (L) arm edematous (+1), (+) radial pulse equal (BIL). Pt restraints in S/Sx of skin/circulation compromise. Plan: monitor O2 sats, enc IS, enc po, enc AMB. Will monitor. [redacted]
24NOV03 @ 1600	Assumed care of pt. @ 0600. VSS. A&O, Ø c/o pain. Staples to (L) anterior chest, open to air, Ø drainage. Pt. on 4L O2 in bed. Pt. ambulates to BR w/ difficulty. New IVSL to (R) upper arm 20G, flushes well. Pt. tol. reg. diet well. Void @ bedside c/u. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] LT, AW
29NOV03 @ 2330	assumed care of pt @ 1800. VSS, no c/o pain. (L) chest incs OTA, sutures CDI. LS OTA, ↓ (L) base, IS enc, RA sats 95%. (R) PIV flushes well, IV Abx cont. Pt ↑ CHAIR x 2°, tol well. Tol regular diet well, void QS per BR/urinal. 2pt restraints on S/Sx skin/circulation compromise. (R) femoral line HL flushes easily. (L) arm cont. +1 edematous, (+) radial pulse, Ø c/o pain. Plan: cont IV Abx, monitor incision, monitor O2 sats. [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

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PROGRESS NOTES
Medical Record

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USAPA V1.00

[redacted] (b)(6)-1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30NOV03E 1700.	Assumed care of pt. @ 0600, VSS, Ø c/o pain, Staples intact to left anterior chest incision, open to air, Ø drainage. BS ↓ to ⓛ LLF, ⊕ BS all 4 quads, ⊕ pulses to all extremities. O_2 NC off, pt. ~~[illegible]~~ (error) MS. O_2 sat 95% on RA. IVSL to ⓡ upper arm, flushes well. Pt. ambulates to BR ⅋ assist., steady gait. Pt. on 2-point restraints in bed, Ø signs of skin breakdown. All other assessments WNL. [redacted]
2200 30 hrs	Called to see re abd pain. c/o pain all over abd not specific, had for days ago, Ø emesis, BM x 1 today. PE: P 120 afeb sat 92%. chest - few rales. abd - rounded soft UH - non tender (b)(6)-2 BS ⊕ x active. c/o pain all over, but no rebound, is moving during Ø. A - abd pain ? etiol. P - CXR re ↓ O_2 sat, CBC; if persistent pain KUB, possibly GB U/S. [redacted]
2215 30NOV03 EVENT	See above MD note also. Pt moaning, c/o pain to abdomen. Interpreter called. Pt c/o sudden ↑ in pain (started 1 hour ago) to mid abdomen. Abd soft, ⊖ rebound tenderness ⊕ TTP ⊕ BS ⊕ BM this afternoon. HR 110s-130 bpm, resp 26-30, O_2 sats 92% RA, ↑ to 4L NC to 98%. MD @ BS, ABL drawn, CXR completed. Nyquil given (CONT)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30NOV02 2215	(CONT) as ordered, IVFs started. MD pulled (R) femoral line. Plan: unit monitor sats, pain. [redacted]
30NOV02 2245	- CBC returned, WBC ↑ 13.5 (8.9 this AM). CXR completed, MD notified. [redacted]
1DEC02 @0100	Pt resting quietly @ this time. HR ↓ 95-97 bpm, O2sats 98-99% 3LNC, states pain is better (decreased). LS CTA, ↓ bases, IS encourage. (D) chest incision OTA, sutures intact. Pt ↑ to chair earlier in shift x ½ hour. IVFs cont to (R) upper arm PIV. Voiding amber urine QS, tol 30% of dinner meal. Plan: monitor O2sats, monitor abd pain, encourage IS & po intake. [redacted] Addendum: 2pt restraints ON S/Sx of skin/circulatory compromise. [redacted]
1Dec'03 0820	Rec'd report and assumed care of pt. Pt in ↑ right position ⊖ s/s of resp distress pain or discomfort @ present time. Pt has suture in place (A) s/c area. ⊖ drainage around site. Lungs CTA decreased in bases. POX 95% on RA. IVF patent (R) ↑ arm ⊖ s/s of infiltration @ site. BS(+) distal pulse equal bilaterally. ⊖ skin breakdown under 2 point restraints

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
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cont	Pt ate small amount of breakfast. WILL
1 Dec @ 0800	continue to monitor. SSG [redacted] 1WHG
1330	Pt ↑ ambulating in the hallway. Pt stated
	he could not eat the food. It bothers his
	stomach. Pt encouraged to eat small amount.
	Pt completed AM and return to bed. 2 point
	restraints applied per MP's. — [redacted] 1WHG
1400	Pt given ~~it~~ [redacted] ~~percocets~~ percocets for pain. POx 95%
	on RA will continue to monitor — [redacted]
1730	Pt resting comfortably — [redacted] 1WHG
2DEC03 @ 0645	Assumed care of pt @ 1800. VSS. No Hx pain. Alert, speaks
	Arabic. LSCTA uses IS. (D) chest incision CDI, OTA, & S/SX
	of infection. Tol 50% of dinner. Voids w/ difficulty. Pt ↑ CHX
	2 hours, ambs to BR w/ difficulty. IVF cont. Plan: encpo,
	monitor sats (currently 98% RA), enc IS/C/DB. 2pt restraints
	WNL S/SX of skin/circulation compromise. Will continue
	to monitor. — [redacted]
2DEC03 @ 1900	Assumed care of pt @ 0600. VSS, A&O, Ø c/o pain. Incision to
	(C) upper chest closed w/ sutures, well approx., Ø drainage,
	open to air. Lung sounds clear bilat. Pt. OOB → BR,
	ambulates w/ difficulty, steady gait. Urinal @ bedside → CYU.
	LRC 150cc/hr to (R) upper arm, Ø S/SX of infiltration. Pt. ate 20%
	of breakfast, tol. well. Pt. in 2-point restraints, Ø signs of
	skin breakdown. All other assessments WNL. Will cont. to monitor.
	— [redacted] CT, AK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 Nov 03 1745	Received report from previous shift. Pt performed ADL care 3 assistance. Physician @ bedside to D/C chest tube. Dressing applied. VS remain stable. Pt voids per urinal. Orders written (or transfer to ward). Will continue to monitor. [redacted]
25 Nov 03 1200	Pt resting in bed. MSO4 drip D/C'D. C/O C/O @ thoracotomy. Will continue to monitor [redacted] (b)(6)-2
26 Nov 03	Surgery Pt doing well AVSS Chest improving Wound C/D/I erythema ODC Ext - (L) arm edema Dx: GSW to Chest / Subclavian vein thrombus Px: Cont heparin / Coumadin To carry Saturday (b)(6)-4 [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.)* | 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

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
19 Nov 05	0650		Received patient from OR [illegible] sedation sheet;
			NIBP 70/40; vented with manual 80/40; PT
			unresponsive to stimuli; sedation off; no ETCO2
			[illegible] x1. Current assessment as follows (please
			see flow sheet for #s); PERRL; [illegible] open
			eyes to painful stimuli / voice; PGSCL 2 min;
			MSO4 / versed for pain / sedation; versed
			currently off; 3mg IVP [illegible] x1; MSO4 @ 2 cc/hr;
			(R) # 8 ETT 24cm @ lip; [illegible] SIMV 14;
			TV 750; PEEP 5; CTA thoraxt; PK PIPs <28;
			Suctioning for minimal amt of white → clear
			secretions; CT x2 to (L) side - 20cm suction;
			(-) S/S of cyanosis; warm distal tips; (CV) NSR;
			pt does go to [illegible] upon agitation; (MSR in
			FOS) NIBP 110-130/60s; +2 pulses x4 ext; (-) edema;
			sensitive (hyperapplicated [illegible]); PGL; GSVD, S1, S2
			(K+ S.G - will notify MD); (GI) NDM, soft hyperactive
			bowel sounds; JP from UQL to suction;
			NGT to LWS; (GU) foley to gravity; (Lines) ETT,
			NGT, foley, (R) SC cath, (L) PIV to LE; JP; -DSNS
			w/ 20 PEEP; (Skin) (L) upper shoulder c/d; C/D/I
			PLA-7 aggressive pulmonary suctioning; monitor
			resp status; [redacted]
			(Co[redacted]

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

REGISTER NO. (b)(6)-2

WARD NO. ICU 3

[redacted] (b)(6)-4

NURSING NOTES
Medical Record

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
19NOV03	830		Pt arrivals; Bolus x2 fluids; Pt with exhibits; call relatives cpt; ABX obtained. [redacted]
			(b)(6)-2
	1170		Pt exhibited with [redacted] Arousable; follow commands; Sats 100% on 35% FiO2; Operation next afternoon; BP 8; Pt <27; exhibits difficulty; Placed on NRB 10L; will titrate for [redacted]
	1513		VSS; NSR in 80s-90s; NIBP 85-90/60s; Improved oxygen sats 2/LNC; sats 100%; CT & WS clsg A'd - [redacted]
	1002		Pt OOB to chair @ 1800; c/o SOCC x3 hrs; Bsps of water; sats 100% on 4L NC in chair; Pain relieved with meds, gtt (1.5mg). On [redacted] shift given report - [redacted]
			(b)(6)-2

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 30 ?? HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☑ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION: 3. PREVIOUS SURGERY [ ] NO ?? [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I & D (L) Chest wall

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Dry
Tobacco ?? ppd X___vrs Body Piercing ?? Diabetes (Y) (N) ? ROM ___ 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: ?

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ potential for anxiety related to: ✓ 1) Surgical Procedure& Operating Room Environment ✓ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	✓ Pt. verbalizes any specific anxiety. ✓ Pt. Exhibits relaxed body posture.	✓ O. Allow pt. to verbalize freely. ✓ O. Explain Or environment and answer questions regarding surgery. ✓ O. Offer comfort measures. (e.g. warm blanket. touch). ✓ O. Explain all nursing procedures before they are done. ✓ O. Remain with pt. Whenever possible. O. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ 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

VERIFICATIONS AT HOLDING AREA:

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ____ Potential for inadequate tissue perfusion due to: ____ 1) Intraoperative Mobility ____ 2) Positioning ____ 3) Existing Disease ____ 4) Safety Devices ____ 5) Hypothermia	O. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check 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. Speak clearly and slowly. O Address pt. from Both side. O Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS OR continuation of above interventions.

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

_____ _____ DATE

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

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

LEVEL OF ACTIVITY: ☐ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] (b)(6)-2

DATE: 19NOV03 TIME: 0100

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 19NOV03 TIME: 0050

REVERS OF FORM 5179, JUN 81

USAPA V1.0

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATIN[illegible]M VIA LITTER BY ANESTHESIA

2. PATIENT IDENTI[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] (Emergency

3. DATE 19Nov03 TIME PATIENT ARRIVED IN SUITE 0105

4. PATIENT IN ROOM TIME 0106 NUMBER 27

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Intubated - Sedated.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt placed on bed, anatomically aligned neutral

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

COMMENTS: Arms on arm board <90° supported strap above knees 2". All pts.

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☑ RAZOR Dr [redacted]

☐ CLIP Chest wall

COMMENTS: pt cut or mess noted

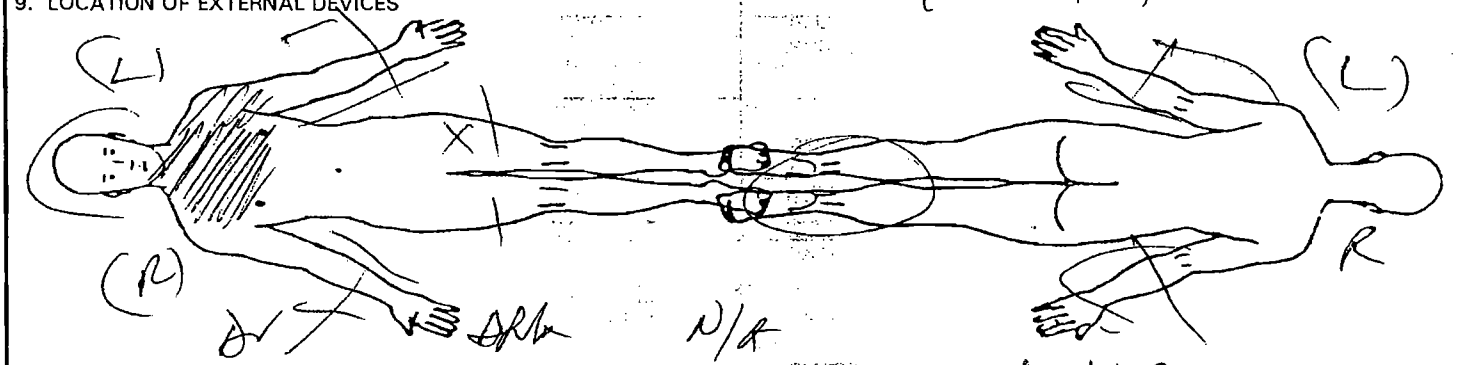
PREP SOLUTION (Specify) Betadine/Betadine

SITE: (B) chest wall BY WHOM:

SITE: chin to nipple BY WHOM: DE [redacted]

COMMENTS: pt complaining of Betadine allergy

9. LOCATION OF EXTERNAL DEVICES



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

(b)(6)-2

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No				[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: Valley Lab Bovie

GROUND PAD: BRAND Polyhesive Plus

LOT NO: 69441 03/2005

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS E 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):
Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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		

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
TAPE

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16 Fr Foley	2. 2 Lt (EMT)	3. 10 mm JP
SITE	1. Bladder (EMT)	2. (L) chest wall	3. (L) chest wall

19. ADDITIONAL INFORMATION
[redacted] A: [redacted] TYPE : GETA

(5)(6)-2
Bone set clear, dry intact pt. pt. pt. op
Dressing dry & clean, intact

20. OPERATION(S) PERFORMED
I & D (L) chest wall

21. PATIENT TRANSFERRED TO ICU 3 TIME 0245 METHOD Ur Hr

22. REGISTERED NURSE SIGNATURE [redacted]

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 2003 — DAY: 26, 26, 27, 28, 29, 30, 1

HOUR

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

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°

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

O2 Sat

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. ICW

[redacted]

(5)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR	DAY 2 Dec
19	HOUR 8 8 8

PULSE (0)	TEMP. F (°)	TEMP. C (Centigrade Equivalents, for Reference only)
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	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: 24

BLOOD PRESSURE: 111/61

T: 97.1, 97.4

HEIGHT: WEIGHT →

Record special data only when so ordered: 97.6

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]

(5)(4-4

(b)(6)-2

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

DATE: 18 NOV 03 TIME: 2350 SSN: [redacted]

(Piccolo) Metabolic Panel

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____141 mmol/L
K_____4.1 mmol/L
TCO2_____22 mmol/L
iCa_____1.05 mmol/L
Hct_____27 %PCV
Hb*_____9 g/dL
*via Hct

At 37C
pH_____7.306
PCO2_____40.9 mmHg
PO2_____169 mmHg
HCO3_____20 mmol/L
BEecf_____-6 mmol/L
sO2*_____99 %
*calculated

At Patient Temp
pH_____7.340
PCO2_____36.8 mmHg
PO2_____156 mmHg

Patient Temp: 94.3F
FIO2_____: 60
Sample Type_: ART

19NOV03 00:43

Oper: [redacted]

Physician:_____

Ser# 42011
Ver: JAMS046A
CLEW A93

(b)(6)-4

======= PICCOLO =======
19/11/03 00:00
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100494

GLU	148*	73-118	MG/DL
BUN	13	7-22	MG/DL
CA++	6.9*	8.0-10.3	MG/DL
CRE	1.8*	0.6-1.2	MG/DL
NA+	141	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	110*	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

======= PICCOLO =======
19/11/03 00:12 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: 013 DR #: 000
SERIAL #: 0000100684

ALB	3.0*	3.3-5.5	G/DL
ALP	52	26-84	U/L
ALT	22	10-47	U/L
AMY	102*	14-97	U/L
AST	45*	11-38	U/L
TBIL	0.4	0.2-1.6	MG/DL
GGT	20	5-65	U/L
TP	5.3*	6.4-8.1	G/DL

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

TE: LAB ID NO.:

(b)(6)-2

Ward Section: Gn6 | REQUIS: [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

DATE: 18 nov | TIME: 2050 | SSN: [redacted] (b)(6)-4

Urinalysis			Hematology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color	straw	N/A	RPR		Negative
Appr	clear	N/A	Mono		Negative
Glu	neg	Negative	Microbiology		
Bili	neg	Negative	Source		
Ket	neg	Negative	Gram Stain		
SG	1.005	N/A	Occ Bld		Negative
Bld	mod	Negative	H. pylori		Negative
pH	6.0	N/A	Micro Parasites		
Prot	neg	Negative	Malaria		
Urob	neg	0.2-1.0	O & P		
Nit	pos	Negative	Other		
Leuk	neg	Negative	Microscopic Urinalysis		
HCG		Negative	Clinitest - neg 3-5 RBCs		

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Precipitigen		Negative	ABO/Rh	B pos

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

UNIT	TYPE	CROSSMATCH

LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/19/03 00:04

Patient ID: [redacted]
Test Name :PT
Test Result:= 17.0 sec.
Ratio = 1.4
~~Calculated INR = 1.71~~
Sample Type:citrated wh. blood
Test Date :11/19/03
Test Time :00:03
Card Lot :080201
Operator [redacted]

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/19/03 00:07

Patient ID: [redacted]
Test Name :APTT
Test Result:= 27.0 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/19/03
Test Time :00:05
Card Lot :110214
Operator : [redacted]

(b)(6)-2

Ward/Section: ICU3	REQUESTING PHYSICIAN: (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 19/11 TIME 0500	SSN/PSEUDO SSN:

(i-STAT)			(Piccolo) Chemistry 17			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	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/						
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-1		
Drug of Abuse		

======= PICCOLO =======
19/11/03 05:2?_AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 013 DR #: 000
SERIAL #: 0000100684

GLU	217*	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	7.1*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	138	128-145	MMOL/L
K+	5.6*	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

======= PICCOLO =======
19/11/03 05:29
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: 013 DR #: 000
SERIAL #: 0000100494

ALB	2.7*	3.3-5.5	G/DL
ALP	39	26-84	U/L
ALT	22	10-47	U/L
AMY	144*	14-97	U/L
AST	44*	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
GGT	17	5-65	U/L
TP	4.8*	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4

Ward/Section:	REQUESTING PHYSICIAN:	LABORA[redacted]FORM
LAST, FIRST, MI.	DATE	TIME [redacted] PSEUDO SSN:

(Privacy Act of 1974)

(Hematology) CBC

(b)(6)-4

ID: [redacted] 19-11-03
WB 05:22

			Patient Limits	
WBC	8.3	x10^3/uL	4.5	10.5
RBC	3.93 L	x10^6/uL	4.00	6.00
Hgb	11.6	g/dL	11.0	18.0
Hct	34.7 L	%	35.0	60.0
MCV	88.4	fL	80.0	99.9
MCH	29.6	pg	27.0	31.0
MCHC	33.5	g/dL	33.0	37.0
Plt	163.	x10^3/uL	150.	450.
LY%	10.6 *L	%	20.5	51.1
LY#	0.9 *L	x10^3/uL	1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

DATE: LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/19/03 05:24

Patient ID: [redacted]
Test Name :PT
Test Result:= 16.4 sec.
Ratio = 1.3
Calculated INR = 1.61
Sample Type:citrated wh. blood
Test Date :11/19/03
Test Time :05:22
Card Lot :080201
Operator : [redacted]

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/19/03 05:26

Patient ID: [redacted]
Test Name :APTT
Test Result:= 37.0 sec.
Sample Type:citrated wh. blood
Test Date :11/19/03
Test Time :05:24
Card Lot :110214
Operator : [redacted]

(b)(6)-2

(b)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE 4/19 TIME 0820	SSN/PSEUDO SSN:

(b)(6)-2

(i-STAT)

TEST RESULT

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____139 mmol/L

K_____5.2 mmol/L

tCO2_____22 mmol/L

iCa_____0.98 mmol/L

Hct_____31 %PCV

Hb*_____11 g/dL

* is Hct

7.335

39.6 mmHg

130 mmHg

21 mmol/L

-5 mmol/L

sO2* _____99 %

*calculated

At Patient Temp

pH_____7.331

pCO2_____40.1 mmHg

pO2_____132 mmHg

Patient Temp: 99.1F

FIO2_____: 35

Sample Type_:

19NOV03 08:25

Oper: [redacted]

Physician:_____

Ser# 42015

Ver: JAMS046A
CLEW A93

_____

(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
GGT		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORT DATE:

LAB ID NO.:

(b)(6)-2

Ward/Section: 1C43	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 11/19 / TIME 1015	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC			Color		N/A	RPR		Negative
			App		N/A	Mono		Negative
			Glu		Negative	**Microbiology**		
			Bili		Negative	Source		
			Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			

(b)(6)-4

ID: [redacted]
MB

19-11-03
10:17

			Patient Limits	
WBC	11.1 H	x10^3/uL	4.5	10.5
RBC	3.77 L	x10^6/uL	4.00	6.00
Hgb	10.9 L	g/dL	11.0	18.0
Hct	34.0 L	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	199.	x10^3/uL	150.	450.
LYZ	10.7 *L	%	20.5	51.1
LYW	1.2 *	x10^3/uL	1.2	3.4

Sp Hemat...			CSF			Blood Bank	
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted]	DATE: 19Nov03	LAB ID NO.:

(b)(6)-2

(b)(4)-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 20 Nov 03	TIME 0425	SSN/PSEUDO SSN:

(b)(4)-2

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph			

Urinalysis

TEST
Color
App
Glu
Bili
Ket
SG
Bld
pH
Prot
Urob
Nit
Leuk
HCG

[redacted]

20-11-03
04:52

			Patient Limits	
WBC	10.4	x10^3/uL	4.5	10.5
RBC	3.22 L	x10^6/uL	4.00	6.00
Hgb	9.4 L	g/dL	11.0	18.0
Hct	28.7 L	%	35.0	60.0
MCV	89.2	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	32.7 L	g/dL	33.0	37.0
Plt	143. L	x10^3/uL	150.	450.
LY%	15.1 *L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

Misc. Serology

TEST	RESULT	REF. RANGE
		Negative
		Negative

Microbiology

		Negative
		Negative

Microscopic Urinalysis

Blood Bank

Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Directigen		Negative	ABO/Rh

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

UNIT	TYPE	CROSSMATCH

E:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 05:32

Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:= 14.7 sec.
Ratio = 1.2
Calculated INR = 1.35
Sample Type:citrated wh. blood
Test Date :11/20/03
Test Time :05:30
Card Lot :080201
Operator [redacted]

(b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/20/03 05:34

Patient ID: [redacted]
Test Name :APTT
Test Result:= 20.7 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/20/03
Test Time :05:32
Card Lot :110214
Operator [redacted]

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

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

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146						
K		3.5-4.9 m						
Cl		98-109 m						
pH		7.31-7.45						
PCO2		35-45 mmHg 41-51 mmHg						
PO2		80-105 mmHg N/A (vent)						
TCO2		23-27 mmol/l 24-29 mmol/L						
HCO3		22-26 mmol/L 22-28 mmol/L						
sO2		95-98%						
BEecf		(-2) – (+3) mmol/L						
AnGap		10-20 mmol/L						
Ca		1.12-1.32 mmo.						
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						

(5)(6)-4

======= PICCOLO =======
20/11/03 04:57
REFERENCE RANGE: [redacted]
PATIENT #:
LIVER PANEL PLUS
DISC LOT #: 3154AA7
DR #: 000
OPER #: 013 0000100494
SERIAL #:

ALB	2.5*	3.3-5.5	G/DL
ALP	46	26-84	U/L
ALT	12	10-47	U/L
AMY	107*	14-97	U/L
AST	33	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	16	5-65	U/L
TP	4.9*	6.4-8.1	G/DL

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

======= PICCOLO =======
MALE 20/11/03 05:30
REFERENCE RANGE: [redacted]
PATIENT #:
METLYTE 8 3152AA4
DISC LOT #: DR #: 000
OPER #: 013 0000100697
SERIAL #:

GLU	136*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.7*	0.6-1.2	MG/DL
CK	1077*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

Misc. Chemistry		
TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

						tCO_2	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 20 NOV / TIME: 1600	SSN/PSEUDO-SSN: [redacted]

(b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
R		
H		
H		
M		
Pl		
L		
Se		
B		
L		
A		
R		
M		
Sp		
Hematocrit		37-47% (F)
Sed Rate		
Other		

ID: [redacted] 20-11-03
MB 16:01

				Patient Limits	
WBC	11.7 H	x10^3/uL		4.5	10.5
RBC	3.44 L	x10^6/uL		4.00	6.00
Hgb	10.1 L	g/dL		11.0	18.0
Hct	30.7 L	%		35.0	60.0
MCV	89.2	fL		80.0	99.9
MCH	29.3	pg		27.0	31.0
MCHC	32.8 L	g/dL		33.0	37.0
Plt	120. L	x10^3/uL		150.	450.
LY%	15.3 *L	%		20.5	51.1
LY#	1.8 *	x10^3/uL		1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 21 Nov / TIME 0420	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		
Hgb		
Hct		
MC'		
Plt		
Lym		
(l		
Seg		
Bar		
Lyr		
Aty		
RE Morph		

(b)(6)-4

ID: [redacted]
WB 21-11-03 04:31

				Patient Limits	
WBC	10.3		x10^3/uL	4.5	10.5
RBC	3.48	L	x10^6/uL	4.00	6.00
Hgb	10.1	L	g/dL	11.0	18.0
Hct	31.2	L	%	35.0	60.0
MCV	89.7		fL	80.0	99.9
MCH	29.1		pg	27.0	31.0
MCHC	32.5	L	g/dL	33.0	37.0
Plt	119.	L	x10^3/uL	150.	450.
LYM%	18.1	*L	%	20.5	50.0
LYM	1.9	*	x10^3/uL	1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
1C43	[redacted]	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4 [redacted]	21 Nov 03	2250	

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

DATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/21/03 23:22

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 14.7 sec.
Ratio = 1.2
Calculated INR = 1.35
Sample Type:citrated wh. blood
Test Date :11/21/03
Test Time :23:20
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/21/03 23:25

Patient ID: [redacted]
Test Name :APTT
Test Result:= 78.5 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/21/03
Test Time :23:22
Card Lot :100208
Operator [redacted]

STAT ICU 3

Ward/Section: ICU# 3	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted]	DATE 22Nov03 TIME	SSN/PSEUDO SSN:

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph		
(Hem		
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		

(b)(6)-4

ID [redacted] 22-11-03
WB 08:24

			Patient Limits	
WBC	10.6 H	x10^3/uL	4.5	10.5
RBC	4.11	x10^6/uL	4.00	6.00
Hgb	12.0	g/dL	11.0	18.0
Hct	37.2	%	35.0	60.0
MCV	90.4	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	194.	x10^3/uL	150.	450.
LY%	13.0 *L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
		N/A
		N/A
		Negative
		Negative
		Negative
		N/A
		Negative
		N/A
		Negative
		0.2-1.0

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Spun Hematocrit		42-52% (M) 37-47% (F)	C	
Sed Rate			Cell Count	
Other			Directigen	

Coagulation Studies (MUST SU

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

REMARKS:

REPORTED BY: DATE:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/22/03 08:27

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 12.9 sec.
Ratio = 1.1
Calculated INR = 1.09
Sample Type:citrated wh. blood
Test Date :11/22/03
Test Time :08:26
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/22/03 08:29

Patient ID [redacted]
Test Name :APTT
Test Result:= 24.6 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/22/03
Test Time :08:27
Card Lot :100206
Operator [redacted]

(b)(6)-2

Ward/Section:	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: (b)(6)-4 [redacted]	DATE: 22 Nov	TIME: 1420	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
			ot		Negative	Malaria		
			ob		0.2-1.0	O & P		
			t		Negative	Other		
			uk		Negative	**Microscopic Urinalysis**		
			CG		Negative			

CSF			Blood Bank	
ell ount			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
rectigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

TE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/22/03 14:26

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 13.3 sec.
Ratio = 1.1
Calculated INR = 1.15
Sample Type:citrated wh. Blood
Test Date :11/22/03
Test Time :14:24
Card Lot :086201
Operator : [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/22/03 14:29

Patient ID: [redacted]
Test Name :APTT
Test Result:= 43.5 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. Blood
Test Date :11/22/03
Test Time :14:26
Card Lot :100208
Operator : [redacted]

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST [redacted]	DATE 23NOV03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

WB	
RB	
Hgb	
Hct	
MCV	
Plt	
Lymp	
(He	
Segs	
Bands	
Lymph	

ID: [redacted] 23-11-03 04:24

WB

			Patient Limits	
WBC	6.5	x10^3/uL	4.5	10.5
RBC	3.38 L	x10^6/uL	4.00	6.00
Hgb	9.7 L	g/dL	11.0	18.0
Hct	30.1 L	%	35.0	60.0
MCV	88.9	fL	80.0	99.9
MCH	28.8	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	213.	x10^3/uL	150.	450.
LYZ	26.2	%	20.5	51.1
LYM	1.7	x10^3/uL	1.2	3.4

(b)(6)-4

RAPIDPOI[illegible]G ANALY[illegible]
SERIAL #0[illegible] [illegible] 11/23/[illegible]

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.8 sec.
Ratio = 1.1
Calculated INR = 1.22
Sample Type:citrated wh. blood
Test Date :11/23/03
Test Time :04:25
Card Lot :080201
Operator : [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #085485 11/23/03 04:29

Patient ID: [redacted]
Test Name :APTT
Test Result:= 30.7 sec.
Sample Type:citrated wh. blood
Test Date :11/23/03
Test Time :04:27
Card Lot :100208
Operator [redacted]

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
G		N/A
ld		Negative
f		N/A
ot		Negative
ob		0.2-1.0
		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

	Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

DATE:	LAB ID NO.:

Ward/Section:	REQUEST [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST [redacted]	DATE	TIME 0730	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10
RBC		4.7-6.1
Hgb		14-18 12-16
Hct		42-52% 37-47%
MCV		80-94 81-99
Plt		130-500 verified
Lymph %		20.5-51

(Hematology) Manual Diffe

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	

ID [redacted]
WB

24-11-03
07:46

			Patient Limits	
WBC	7.2	x10^3/uL	4.5	10.5
RBC	3.44 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	30.9 L	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	266.	x10^3/uL	150.	450.
LY%	23.6	%	20.5	51.1
LY#	1.7	x10^3/uL	1.2	3.4

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

DATE: | LAB ID NO.:

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/24/03 07:50

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.6 sec.
Ratio = 1.3
Calculated INR = 1.49
Sample Type:citrated wh. blood
Test Date :11/24/03
Test Time :07:49
Card Lot :080201
Operator : [redacted]

(b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/24/03 07:53

Patient ID [redacted]
Test Name :APTT
Test Result:= 35.3 sec.
Sample Type:citrated wh. blood
Test Date :11/24/03
Test Time :07:51
Card Lot [redacted]

Ward/Section: T Cu 3	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted]	DATE 11/23/03	TIME 1430	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M 37-47% (F	
Sed Rate			
Other			

Coagulation Studies

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

REMARKS:

REPORTED BY: [redacted]

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

T SUBMIT SF 518 WITH RY UNIT REQUESTED

Rh

smatch

RY UNIT OF BLOOD

CROSSMATCH

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/23/03 14:43

Patient ID [redacted]
Test Name :PT
Test Result:= 14.8 sec.
Ratio - 1.2
Calculated INR = 1.37
Sample Type:citrated wh. blood
Test Date :11/23/03
Test Time :14:41
Card Lot :080201
Operator [redacted]

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/23/03 14:45

Patient ID: [redacted]
Test Name :APTT
Test Result:= 30.9 sec.
Sample Type:citrated wh. blood
Test Date :11/23/03
Test Time :14:43
Card Lot :100208
Operator [redacted]

(b)(6)-2

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-2	DATE: 25 Nov 03	TIME: 0800	SSN/PSEUDO SSN:

(Hematology) CBC (b)(6)-4

ID [redacted] 25-11-03
WB 04:05

			Patient Limits	
WBC	8.1	x10^3/uL	4.5	10.5
RBC	3.49 L	x10^6/uL	4.00	6.00
Hgb	10.1 L	g/dL	11.0	18.0
Hct	31.5 L	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	304.	x10^3/uL	150.	450.
LY%	18.3 L	%	20.5	51.1
LY#	1.5	x10^3/uL	1.2	3.4

Atyp		Immm	

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

DATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/25/03 04:10

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 14.3 sec.
Ratio = 1.2
Calculated INR = 1.29
Sample Type:citrated wh. blood
Test Date :11/25/03
Test Time :04:08
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/25/03 04:12

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.0 sec.
Sample Type:citrated wh. blood
Test Date :11/25/03
Test Time :04:10
Card Lot :100208
Operator : [redacted]

(b)(6)-2

Ward/Section: 2CWS | [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | DATE: 26 NOV | TIME: 0500 | SSN/PSEUDO SSN:

(b)(6)-4

[redacted]
MD

26-11-03
05:20

			Patient Limits	
WBC	18.2 H	x10^3/uL	4.5	10.5
RBC	3.48 L	x10^6/uL	4.00	6.00
Hgb	9.9 L	g/dL	11.0	18.0
Hct	31.4 L	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	302.	x10^3/uL	150.	450.
LY%	2.7 *L	%	20.5	51.1
LY#	0.5 *L	x10^3/uL	1.2	3.4

Bands

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App		N/A	Mono		Negative
Glu		Negative	**Microbiology**		
Bili		Negative	Source		
Ket		Negative	Gram Stain		
SG		N/A	Occ Bld		Negative
Bld		Negative	H. pylori		Negative
pH		N/A	Micro Parasites		
Prot		Negative	Malaria		
Urob		0.2-1.0	O & P		
Nit		Negative	Other		
Leuk		Negative	**Microscopic Urinalysis**		
HCG		Negative			

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

E: | LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/26/03 05:23

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.4 sec.
Ratio = 1.3
~~Calculated INR = 1.46~~
Sample Type:citrated wh. blood
Test Date :11/26/03
Test Time :05:21
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/26/03 05:25

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.8 sec.
Sample Type:citrated wh. blood
Test Date :11/26/03
Test Time :05:23
Card Lot :100208
Operator : [redacted]

(b)(6)-2

Ward/Section: ICW#1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, M: [redacted] (b)(6)-4	DATE: 27NOV	TIME: 1615	SSN/PSEUDO SSN: [redacted]

(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
			H		N/A	Micro Parasites		
			rot		Negative	Malaria		
			rob		0.2-1.0	O & P		
			it		Negative	Other		
			euk		Negative	Microscopic Urinalysis		
			ICG		Negative			

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

TE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/27/03 16:07

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.8 sec.
Ratio = 1.3
Calculated INR = 1.52
Sample Type:citrated wh. blood
Test Date :11/27/03
Test Time :16:06
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/27/03 16:11

Patient ID: [redacted]
Test Name :APTT
Test Result:= 73.9 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/27/03
Test Time :16:08
Card Lot :100208
Operator : [redacted]

(b)(6)-2

Ward/Section: ICW 1	REQUESTING [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 22 NOV	TIME: 0820	SSN/PSEUDO SSN:

(b)(6)-4

Hematology			
T			
WB	[redacted]	23-11-03	
RBC		6:45a	
High		Inherent Limits	
Hct	[illegible]	[illegible]	[illegible]
MCV	[illegible]	[illegible]	[illegible]
Plt	[illegible]	[illegible]	[illegible]
Lymp	[illegible]	[illegible]	[illegible]
(H	[illegible]	[illegible]	[illegible]
Segs			
Band			

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App		N/A	Mono		Negative
Glu		Negative	**Microbiology**		
Bili		Negative	Source		
Ket		Negative	Gram Stain		
SG		N/A	Occ Bld		Negative
Bld		Negative	H. pylori		Negative
pH		N/A	Micro Parasites		
Prot		Negative	Malaria		
Urob		0.2-1.0	O & P		
Nit		Negative	Other		
[illegible]k		Negative	**Microscopic Urinalysis**		
[illegible]G		Negative			

CSF			Blood Bank	
[illegible]ell [illegible]ount			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
[illegible]irectigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

[illegible]ATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/27/03 04:57

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 17.5 sec.
Ratio = 1.4
[redacted]
Sample Type:citrated wh. blood
Test Date :11/27/03
Test Time :04:56
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/27/03 05:00

Patient ID: [redacted]
Test Name :APTT
Test Result:= 59.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/27/03
Test Time :04:57
Card Lot :100208
Operator : [redacted]

(b)(6)-2

Ward/Section: ICW 3	REQUESTING [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 7 NOV	TIME: 0520	SSN/PSEUDO SSN:

(Hematology) CBC [redacted]

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18 g/dl (M 12-16 g/dl (F
Hct		42-52% (M 37-47% (F
MCV		80-94 fl (M 81-99 fl (F
Plt		150-500 x 1 verified
Lymph %		20.5-51.1

(Hematology) Manual Differ

WBC	9.0	x10^3/uL					
RBC	3.58 L	x10^6/uL					
Hgb	10.7 L	g/dL					
Hct	31.8 L	%					
MCV	89.0	fL					
MCH	29.9	pg					
MCHC	33.7 L	g/dL					
Plt	270.	x10^3/uL					
Lym	11.9	% L					
Lym	1.1	x10^3/uL					

Patient Limits		
4.5	10.5	
4.00	6.00	
11.9	16.0	
35.0	48.0	
80.0	99.0	
27.0	34.0	
33.0	37.0	
150.	450.	
20.5	51.1	
1.2	3.7	

Urob		
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

TE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/28/03 05:11

Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.5 sec.
Ratio = 1.3
Calculated INR = 1.47
Sample Type:citrated wh. blood
Test Date :11/28/03
Test Time :05:10
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/28/03 05:14

Patient ID: [redacted]
Test Name :APTT
Test Result:= 32.7 sec.
Sample Type:citrated wh. blood
Test Date :11/28/03
Test Time :05:11
Card Lot :100208
Operator : [redacted]

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

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<250 ug/ml
FDP		<10 ug/ml

REMARKS:

REPORTED BY: DATE

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		
Prot		
Urob		
Nit		
Leuk		
HCG		
Cell Coun		
Direct		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

TEST	RESULT	REF. RANGE
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/29/03 05:40

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 18.3 sec.
Ratio = 1.5
Calculated INR = 1.93
Sample Type:citrated wh. blood
Test Date :11/29/03
Test Time :05:39
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/29/03 05:42

Patient ID [redacted]
Test Name :APTT
Test Result:= 27.6 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/29/03
Test Time :05:40
Card Lot :110215
Operator [redacted]

(b)(6)-2

Ward/Section: CW#1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 30 Nov	TIME: 0900	SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE

(b)(6)-4

Urinalysis

TEST	RESULT	REF. RANGE
		N/A
		N/A
		Negative
		Negative
		Negative
		N/A
		Negative
		N/A
		Neg
		0.2-1
		Negat
		Negati
		Negativ

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
[illegible]	Negative

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/30/03 05:34

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 17.4 sec.
Ratio = 1.4
Calculated INR = 1.78
Sample Type:citrated wh. blood
Test Date :11/30/03
Test Time :05:33
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/30/03 05:36

Patient ID [redacted]
Test Name :APTT
Test Result:= 31.6 sec.
Sample Type:citrated wh. blood
Test Date :11/30/03
Test Time :05:34
Card Lot :110215
Operator [redacted]

CSF

		Negati

Blood B
UST SUBMIT SF 51
R

NIT		

APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICW#1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 30 NOV	TIME 2150	SSN/PSEUDO SSN: # [redacted]

(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**		
			Bili		Negative	Source		
			Ket		Negative	Gram Stain		
			SG		N/A	Occ Bld		Negative
			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			

(b)(6)-4

[redacted]

			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.:

(5)(6)-2

Ward/Section: ICW4	REQUESTING PHYSICIAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 30 DEC 03 TIME 0505	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
			RESULT	REF. RANGE		TEST	RESULT	REF. RANGE
				N/A		RPR		Negative
				N/A		Mono		Negative
				Negative		Microbiology		
				Neg				
				Neg				
				N/A	[redacted]			Negative
				Neg				Negative
				N/A				
				Neg				
				0.2				
				Ne				
				Ne				nalysis
				Ne				

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 12/01/03 05:16

Patient ID [redacted] (5)(6)-4
Test Name :PT
Test Result:= 18.6 sec.
Ratio = 1.5
~~Calculated INR = 1.98~~
Sample Type:citrated wh. blood
Test Date :12/01/03
Test Time :05:14
Card Lot :080201
Operator [redacted] (5)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 12/01/03 05:19

Patient ID [redacted]
Test Name :APTT
Test Result:= 31.2 sec.
Sample Type:citrated wh. blood
Test Date :12/01/03
Test Time :05:16
Card Lot :100208
Operator [redacted]

CSF			Blood Bank	
t			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
tigen		Negative	ABO/Rh	

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.:

(b)(6)-2

Ward/Section: CW#4	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 2 DEC / TIME 0510	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE

(b)(6)-4

[redacted]

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

icroscopic Urinalysis

Blood Bank

SUBMIT SF 518 WITH UNIT REQUESTED

match

Y UNIT OF BLOOD

CROSSMATCH

Sed Rate		
Other		

Coagulation Studies

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

REMARKS:

REPORTED BY:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 12/02/03 06:50

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 20.0 sec.
RESULT OUT OF RANGE
Ratio = 1.6
Calculated INR = [redacted]
Sample Type:citrated wh. blood
Test Date :12/02/03
Test Time :06:48
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 12/02/03 06:53

Patient ID [redacted]
Test Name :APTT
Test Result:= 37.1 sec.
Sample Type:citrated wh. blood
Test Date :12/02/03
Test Time :06:50
Card Lot :110215
Operator [redacted]

Incoh ↑
PSH + PMH unknown
? Allergies

Propof 99% 0 ... 1.3 12.9 / 4.8 39 / 200 | 104 | 141 / 110 / 13 / 148 / 4.9 / 22 / 1.8 / 148 | PT 17 INR 1.4 PTT 27 | 9.. | 1L HCO 20 BE-6

Lower lobe pulm contusion

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)	0100	x 30	x 0200	x 30	x 0300											
Vecuronium (MG)	10							10								
Fentanyl (MG)	50	100	50	50												1
( )																
( )																
( )																
( )																
VOLAT AGENT Sevo % del	.8	.8	.8	1.0	0.8	0.8	0.8	1.7								
% e.t.																
AIR L/Min																
N2O L/Min																
O2 L/Min	2	1	1	1.2	1.0	1.0	1.0	2.0								

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

FLUIDS

LINE site																
R Femoral (2)	☐ Warmed	LR														
(2) 18G	☐ Warmed		1000						500							
(1) 18G	☐ Warmed	TKO														
(1) 18G	☐ Warmed	TKO														

LOSSES

EST BLOOD LOSS									100							
URINE -	500															

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

BODY WEIGHT: ≈ 80 KG LB

HEMATOCRIT: 12.9/39

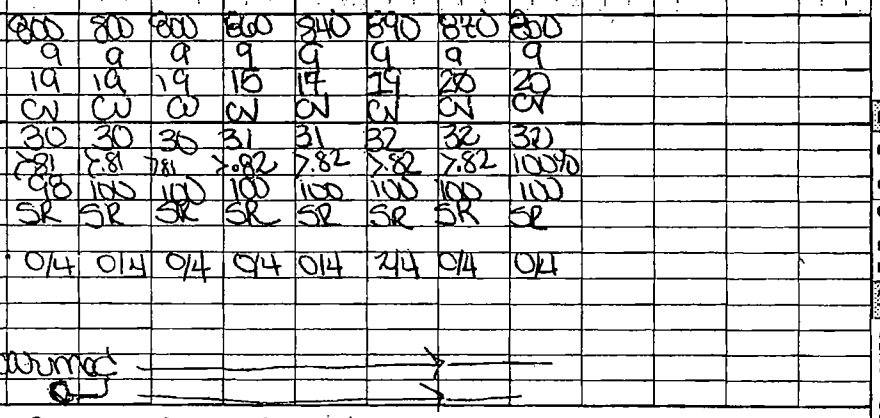
INITIAL DATA: BP- 130/60 HR- 96 0800

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? VLP TIME- 0100

TIME → x 30 x 0200 x 30 x

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



VENTIL

VT - ml	800	800	800	800	840	890	820	800
f - breaths/min	9	9	9	9	9	9	9	9
Peak inf pres / PEEP	19	19	19	16	17	19	20	20
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	30	30	30	31	31	32	32	32
BP/oth	FIO2 (Frac or %)	.81	.81	.81	.82	.82	.82	.82	100%
ART line	X SpO2 (%)	98	100	100	100	100	100	100	100
Steth- PC/ES	X ECG II	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site								
	N-M Block (T/4)	0/4	0/4	0/4	0/4	0/4	2/4	0/4	0/4
Warming blkt	Room warmed								
Conv warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Supine arms <90° tucked

TOTALS

TOTAL EBL	100 ml
TOTAL URINE	1000 ml

FLUIDS - SUMMARY

CRYSTALLOID- 1300 mL LR

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

0000 Prepped as above
TCA started to OR from ER
S/Incident
0300
0500 Report to Angela

RECOVERY AT 0355

PACU (ICU) (Specify)

OTHER

CONDITION: Vent 10 70% FiO2
RESP- SpO2- 100
BP- 107/76 HR- 89

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0000	0100	0355
	Ready	Begin	End
PROC	0116	0120	0245

PROCEDURES and CPT Codes:
Ant Chest wall Debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
8.0 ET c 22 cm at teeth. Replaced from OR ETCO2 x3 12 Chest tubes BBS-CTA

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

PROCEDURE LOCATION: OR2-1

DATE: 9/11/03

PAGE 1 OF 7

MEDCO

DA FORM 7389, FEB 1998 — COPY 1 - PATIENT'S MEDICAL RECORD

518-124 NSN 7540-00-634-415

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1u ML

EMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 18Nov03

DATE AND HOUR REQUIRED ASAP (cal)

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE [redacted]

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 18Nov03

TIME VERIFIED 2355

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO. 66-4

PATIENT NO. [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	compat

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 19Nov03

DONOR	RECIPIENT
ABO O	ABO B
Rh pos	Rh pos

REMARKS: exp 21Nov03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND [redacted] ON (Date) 20,Nov03

IDENTIFICATION

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

1st VERI[redacted] (b)(6)-2

[redacted] AS

PRE-TRAN[redacted]

TEMP. 98.3 PULSE 97 BP 115/87

DATE OF TRANSFUSION 20 Nov 03

TIME STARTED 0943

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ~~ML~~

TIME/DATE ~~COMPLETED/INTERRUPTED~~ 20Nov03 @ 1110

REACTION

- [ ] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.4	98	108/70

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] RN for

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

SEX M

WARD [redacted]

[redacted] (b)(4)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

518-124 NSN 7540-00-634-415

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)* _____ ML

EMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 18 NOV 03

DATE AND HOUR REQUIRED m Cay

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 18 NOV 03

TIME VERIFIED 2355

(b)(6)-2

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 66-4 [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR
ABO O
Rh pos

RECIPIENT
ABO B
Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compat

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE 19 NOV 03

REMARKS: exp 2 Nov 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

(Hour) 0720 ON *(Date)* 20 Nov 03

IDENTIFICATION

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

[redacted] (b)(6)-2

[redacted] 4/AW

PRE-TRANSFUSION

TEMP. 97.4 PULSE 95 BP 110/73

DATE OF TRANSFUSION 20 Nov 03 TIME STARTED 0730

POST-TRANSFUSION DATA

AMOUNT GIVEN Unit ~~ML~~

TIME/DATE ~~COMPLETED/INTERRUPTED~~ 0920 20 Nov 03

REACTION
- [x] ~~NONE~~
- [ ] ~~SUSPECTED~~

TEMPERATURE	PULSE	BLOOD PRESSURE
97.6	70	114/70

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] ~~FEVER~~
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

SIGNATURE [redacted]

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

SEX M WARD [illegible]

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

PCN 7540-01-165-7124 519-30

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
US		M		ICU #3	
(L) Subclavian Vessels	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTING PHYSICIAN [redacted]				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2				DATE REQUESTED 21 NOV 03

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

R/O DVT

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

RADIOLOGIC REPORT

(-) Thrombus (L) basilic ~~cephalic~~ and (L) subclavian vein to area of expected lateral 1/3 of clavicle. (~~extend~~ involves axillary vein).

(b)(6)-2

[redacted]

28 Oct 03

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

(b)(6)-4

[redacted]

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (9-82)
Prescribed by DSS/ISOM
FPMR (41 CFR) 101-11.808

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]

DATE OF ORDER: 19 Nov 03 TIME OF ORDER: 245 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to ICU
S/P HP / closure of chest wall
Critical
VS - Q1°
Act - Bed rest
Nursing - IV's
CT x2 to 20cm Sxn

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

S/P to wall suction (continuous)
NGT to LWS
Vent SIMV 40% 750 PEEP-5 R-14
Foley to gravity
D5 1/2 NS + 20KCl @ 100cc/hr
MEDS: Versed drip 2mg/hr
(may ↑ to 5mg/hr for sedation)

NURSING UNIT | ROOM NO. | BED NO.

noted [redacted] 1700 0400 19 Nov

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Morphine drip 2mg hr (may ↑ to 4mg/hr for pain)
Ancef 1gm IV Q8
Gentamycin 360mg IV QD

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

CBC, Chem-10 PT/PTT / ABG in ICU

PATIENT IDENTIFICATION

DATE OF ORD[redacted]

T.O.: HOURS

1700 19 Nov 03
① NS 1L Bolus run - clamp
② clamp L drains
③ OOB + chair TID [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24° chest | 24 Nov 03 Sa[redacted]

[redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 [redacted]			20 Nov 03	0700 HOURS	
			Transfuse 2 units PRBC		
			Pay Ret		
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE [redacted]	TIME OF ORDER	
			20 Nov 03	0950 HOURS	
			CXR - Follow up chest injury		QD
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			[redacted]	TIME OF ORDER	
			20 Nov	1300 HOURS	
			Colace 100 mg PO BID		
			CBC @ 1600		
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DA[redacted]		
			21 Nov	1520 HOURS	
			CXR		
			heparin drip @ 700 650 unit/hr		
			US of (L) subclavian vessels R/O DVT		
NURSING UNIT	ROOM NO.	BED NO.			
24° chest	24WOU	03 SUT	[redacted]		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

Pt [redacted]

(b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICU3	24	chart / 24NOV03

DATE OF ORDER: 21 NOV 03 TIME OF ORDER: 1723 HOURS

(1) Please draw PT/PTT SIX (6) hours after start of heparin

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 22 NOV 03 TIME OF ORDER: _____ HOURS

PT/PTT, CBC NOW

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted]

DATE OF [redacted]

22 NOV 03 0930 HOURS

↑ Heparin to 1000 units/hr

✓ PT/PTT q 4 hrs

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.

[redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 23 NOV TIME OF ORDER: 0830 HOURS

↑ Heparin to 1200 units/hr

✓ PT/PTT after 6 hour

11/23/03 0830

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4			23 Nov 03	1600 HOURS	
			CT to H&O Seq.		
			V.O. [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
ICU 3	24° chart	24 Nov 0440 [redacted]			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] 24 Nov 03 0730			24 Nov 03	0720 HOURS	
			QAM CBC, PT/PTT		
NURSING UNIT	ROOM NO.	BED NO.			
ICU3			[redacted]		

PATIENT IDENTIFICATION			DATE [redacted] ORDER		
			24 Nov 03	1645 HOURS	
			(1) D/C Foley		
			VO D4 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			25 Nov 03	0710 HOURS	[redacted]
			D/C CT		
			CXR		
			[illegible]		
NURSING UNIT	ROOM NO.	BED NO.	[redacted]		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

25 Nov — 0800 HOURS

Transfer to Floor

s/p GSW to chest

Stable

VS Protocol

Act - OOB

Diet - Reg

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

Nursing - HOURS

maintain IV

4L O_2 via NC

Incentive Spirometer

CBC/PT/PTT QAM

Meds - Ancef 1 gm IV Q8 x5 days

Gentamycin 400 mg IV QD x5 days

Heparin drip @1200 units/hr

PATIENT IDENTIFICATION

Noted [redacted] 25NOV03 1655

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

Colace 100 mg PO BID

Percocet 1 PO Q4 PRN

MSO4 4 mg IV Q4 PRN

Coumadin 3 mg PO QD

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

Noted [redacted] 25 Nov 1800

NURSING UNIT | ROOM NO. | BED NO.

DATE OF [redacted] TIME OF ORDER

11/25/03 HOURS

IVF D5 1/2 NS c̄ 20 mEq KCl/liter

@ 125 cc/hr

[redacted]

26NOV03 0755

Heplock IVFs V.O.D [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] noted [redacted]	27NOV03	1600 HOURS	
	V.O.-Dr. [redacted]		
	Coag Panel x 1 now		
	(b)(6)-2 [redacted]		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]	27NOV03	1706 HOURS	
	(1) Stop Heparin Drip		
	(2) Call lab to check coags as ordered		
	[redacted]		
NURSING UNIT: 24/0013 / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]	2200 30 Nov	HOURS	
	(1) CBC		
	(2) CXR		
	(3) IV 2L at 150 cc/h		
	(4) Mylanta 30 cc po now & q4 prn mild abd pain x 12 hrs only		
NURSING UNIT: 24/0/005D / ROOM NO. / BED NO.	(b)(6)-2 [redacted]		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted]		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

(b)(6)-4

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

[redacted] Medcom 25011

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 TI ORD NOTE
[redacted] (5)(6)-4				1 Dec	1845 HOURS	[redacted]
				Transfer to camp 2 Dec		
					(5)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		[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	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25	26	27	28
19 NOV	[redacted]	VS Q1 Hr	06	[redacted]									
			18										
19 NOV	[redacted]	Activity BR	06	[redacted] D/C 20 NOV									
			18										
19 NOV	[redacted]	CT x1 to 20cm suct	06	[redacted] D/C 23 Nov see below									
			18										
19 NOV	[redacted]	JP to cont wall suct	06	[redacted] D/C									
			18	[redacted] 22 Nov 03									
19 NOV	[redacted]	NG to LIS	06	[redacted]									
			18	D/C'd 19 Oct 03									
19 NOV	[redacted]	Vent ~~SIMV~~ 40%, 750TV	06	[redacted]									
		rate 14 peep 5	18										
19 NOV	[redacted]	Foley to Gravity	06	[redacted] D/C'D									
			18										
19 NOV	[redacted]	OOB to chair TID	06	[redacted]									
			18										
~~19 NOV~~	[redacted]	~~DISC: CLSNG~~	06	[redacted] D/C'd 20 Nov 03									
			18										
20 NOV	[redacted]	Reg Diet	06	[redacted]									
			12										
			18										
20 NOV	[redacted]	CXR - follow up chest injury QD	04	[redacted]									
23 NOV	[redacted]	CT to H2O seal	06	[redacted]									
			18										
21 NOV	[redacted]	CBC, PT/PTT QAM	04	[redacted]									

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW scapula/chest

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 NOV	[redacted]	Admit to ICU, S/P 1½ D/closure chest wall	19 NOV	0245	0300	[redacted]
19 NOV	[redacted]	Condition-critical	19 NOV	0245	0300	[redacted]
19 NOV	[redacted]	CBC, Chem 10, Coag, CXR x1 in ICU	19 NOV	adm		
20 Nov	[redacted]	CBC @ 1600	20 Nov	1600	1600	[redacted]
21 Nov	[redacted]	CXR, US of (L) subclavian vessels				[redacted]
	-----	R/O DVT	done			
21 Nov AM	[redacted]	Please draw PT/PTT 6 hours	21 Nov			
	-----	after start of heparin	21 Nov	2230		
22 Nov 9	[redacted]	PT/PTT, CBC Now	22 Nov 9	0800	0827	[redacted]
22 Nov 9	[redacted]	PT/PTT P 4 HRS	22 Nov	1400	1420	[redacted]
23	[redacted]	PT/PTT AFTER 6 Hrs	23 Nov	1430	1430	[redacted]
24 Nov	[redacted]	D/C Foley	24 N	[redacted]		[redacted]
25 Nov	[redacted]	D/C CT	25 Nov	done		[redacted]
25 Nov	[redacted]	CXR	25 Nov			[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

(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	1	2
25 NOV	[redacted]	VS per protocol	06 18	[redacted]							
			18 06	[redacted]							
25	[redacted]	Act. OOB	06 18	[redacted]							
			18 06	[redacted]							
25	[redacted]	Diet. Reg	06 18	[redacted]							
			18 06	[redacted]							
25	[redacted]	Incentive spirometer	06 18	[redacted]							
			18 06	[redacted]							
25	[redacted]	CBC/PT/PTT q AM Cong Panel	05	[redacted]							
		(b)(6)-2									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

#[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

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
25 NOV	[redacted]	Tx to floor. S/p 6SN to CX. Stable	25 NOV			[redacted]
27 NOV	[redacted]	Coag panel x 1 now	27 NOV			[redacted]
30	[redacted]	CBC, CXR now	done 30 NOV			[redacted]
		(b)(6)-2				

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25	26	27	28
19 NOV	[redacted]	D5½ NS ē 20 KCl @ 100/hr	06	[redacted]									
			18	[redacted]									
19 NOV	[redacted]	Versed gtt 2mg/hr	06	[redacted]	D/C'd 19 Nov 03								
		(may ↑ to 5mg/hr for sed.)	18										
19 NOV	[redacted]	MSO4 gtt 2mg/hr	06	[redacted]									
		(may ↑ to 4mg/hr for pain)	18	[redacted]									
19 NOV	[redacted]	Ancef 1gm IV Q8°	06	[redacted]									
			14	[redacted]									
			2	[redacted]									
19 NOV	[redacted]	Gentamycin 360mg IV QD	10	[redacted]									
20 NOV	[redacted]	Colace 100 mg PO BID	08	[redacted]									
			22	[redacted]									
21 NOV	[redacted]	HEPARIN DRIP ~~700u~~ 1000 mg	06	[redacted]									
		hr	18	[redacted]									
23 NOV	[redacted]	HEPARIN DRIP ↑ 1200u/	06	[redacted]									
		hr	18	[redacted]									

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: GSW scapula/chest

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr._____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
11/19	[redacted]	NS 1L Bolus x1 NM	11/19	1600	1600	[redacted]
20 Nov	[redacted]	Thrs fluid 2 unit PMBC	11-20	~~0900~~ ~~1100~~	0900 1100	[redacted]
	- - - - -					
	- - - - -	(b)(6)-2				
	- - - - -					
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	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
- - - - -	- - - - -															
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 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	1	2						
25 Nov 03	[redacted]	maintain IV @ 125 cc/hr	06 18	[redacted]													
	-----	D5 1/2 NS c 20 mEq KCl/l	13 06	[redacted]													
25	[redacted]	AL O2 via NC	08 13	[redacted]													
	-----		18 00	[redacted]													
25	[redacted]	Ancef 1 gm IV q 8°	06	[redacted]													
	-----	x 5 days	14	[redacted]													
	-----		22	[redacted]													
25	[redacted]	Gentamycin 400 mg	08	[redacted]													
	-----	IV QD x 5 days															
25	[redacted]	heparin drip @ 1200	08 18	[redacted]													
	-----	units/hr	18 00	[redacted]													
25	[redacted]	Zolace 100 mg PO	08	[redacted]													
	-----	BID	20	[redacted]													
25	[redacted]	Coumadin 3 mg Po	08	[redacted]													
	-----	QD															
26 Nov 03	[redacted]	Heplock IVFs flush	06 18	[redacted]													
	-----	q shift	18 00	[redacted]													
26	[redacted]	Gentamycin 400 mg IV	10	[redacted]													
	-----	QD x 5 days															
30	[redacted]	IVFs: LR @ 150 cc/°	6	[redacted]													
	-----		18	[redacted]													

(b)(6)-2

(b)(6)-2

(b)(6)-4

D/C'ed 27 NOV [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to chest

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 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
30	[redacted]	Mylanta 30cc po x1 now	2200	30NOV03		[redacted]
		(b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
25NOV	[redacted]	Percocet II po q4 pm	D/T	25NOV 2240	26NOV 1250	26NOV 2200	27NOV 2000	27NOV 1400								
			D/I	[redacted]												
25	[redacted]	MSO4 4mg IV q4° pm	D/T													
			D/I													
30	[redacted]	Mylanta 30cc po q4° pm mild abd pain x12° only	D/T					auto D/C								
			D/I					1000 10DEC03								

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE	OTSG APPROVED *(Date)*
TRAUMA FLOWSHEET The proponent is Dept of Surgery	QI Appr 11 Jun 97

EMS REPORT

TIME: _____ ETA: _____ UNIT: _____

MED COM: [Y] [N]

ARRIVAL STATUS

TIME 2250 ☐ IV x 3 ☐ O_2 _____ l/min ☐ C-Spine Immob

Meds: ☑ UKN ☐ None ☐ Yes: _____

Allergies: ☑ UKN ☐ None ☐ Yes: _____

Tetanus: ☑ UKN ☐ Current Last Meal/Fluid Intake _____ hrs

LMP: N/A ☐ _____

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

☑ ETT 8.0 ☐ 22 Clip

☐ Secretions _____

BREATHING Intubated on arrival

☐ Labored ☐ Unlabored ☐ Absent

TRACHEA: ☑ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] > = < [R]

CIRCULATION

PULSE: ☑ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☑ Clear ☐ Muffled

SKIN: ☑ Warm ☐ Cool ☐ Hot

☑ Pink ☐ Pale ☐ Cyanotic ☐ _____

☑ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: Intubated on arrival

M _____

SPHINCTER TONE: N/A

☐ WNL

☐ None

HEAD

PUPILS: ☐ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]

TM: ☑ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ _____

JVD: [Y] [N]

HEART

RHYTHM: ☑ Regular ☐ _____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☑ Bilat ☑ Equal ☑ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☑ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: —

PELVIS

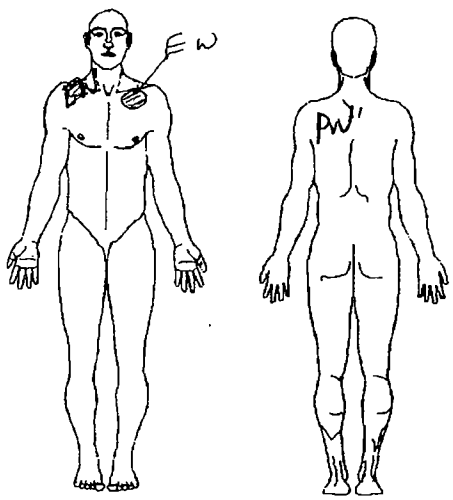
☑ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

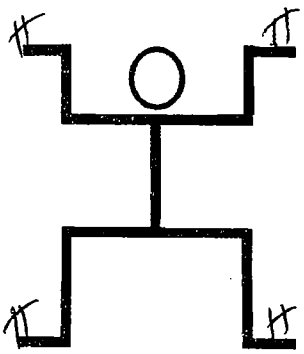
Heme + / ☐ Prostate: ☑ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Doplor

RN [redacted] (b)(6)-2

PHYSICIAN [redacted]

(Continue on reverse)

[redacted]

DEPARTMENT/SERVICE/CLINIC: ER

DATE: 19 NOV 03

(If typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 **4700**

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
arrival	ET Intubation	8.0	☑ Oral ☐ Nasal Teeth 22cm	arrival	☐ $ETCO_2$ Change ☐ BBS Post Int ☑ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified ____ Suction: Y N
arrival	Urinary	16 Fr	☑ Meatus ☐ Supra-Public		☑ Return 900 cc ☐ Heme Dip: + - ☑ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@ ____
arrival	Chest Tube #1		L R		☑ Air ☐ Blood ☑ Pleuravac 20 cm ☐ Autotransfuser
arrival	Chest Tube #2		L R		☐ Air ☑ Blood ☑ Pleuravac 20 cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☑ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
arrival	1	18	Y	N	Rt Arm	NS	500cc	
arrival	2	18	Y	N	Rt Foot	NS	500cc	
arrival	3		Y	N	Rt Femoral	LR	1000cc	
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Ancef	arrival	1 gm	IV						
Tetnas	0005	.5	IM						

ABG SITE	TIME	%O_2	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick ____ ☐ SHct ____
	☐ D-stick ____ ☐ SHct ____
2305	☑ CBC ☑ Chem ☑ PT/PTT
	☐ ETOH ☐ T&S ☑ T&C x 2
	☐ Tox Screen
2355	☑ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

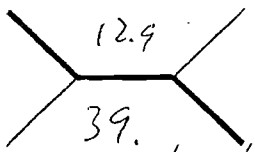
TIME	LABS
0005	☑ Chest Initial
0005	☑ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
0005	☑ Pelvis
0005	☑ Abdomen
	☐
	☐

BLOOD PRODUCTS

START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

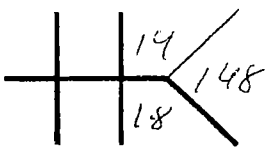
LAB RESULTS

CBC:



P71 P77 / 14 / 27

Chem: LFZS - WNL



UA - WNL

INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	0010 400 cc yellow
NGT		NGT	urine 050
Blood		EBL	1000 cc
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted]	here on Pt arrival		
Surgeon	[redacted]	2400	0005 →	
Anesth	[redacted]	(5)(6)-2		
X-Ray	2355 [redacted]			
RT	here on Pt arrival			
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ ____

Admitted to ICU #

Report Called to ____

Time Transferred ____

Accompanied By ____

Via: ☑ Stretcher ☐ Wheelchair

As per ACLS Precautions: ☑ Yes ☐ No

VITAL SIGNS

Rectal Temp: 92.2

GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
2352	114/71	101	ST	14	93%	100% 10% SPUD					
2400	147/83	96	NS	14	100%						
0005	139/96	93	NS	14	100%						
0013	141/92	84	NS	19	99%						
0023	87/60	88	NS	15	100%						
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

0005 - Warmed NS given
mech. IV D/T BCT
0013 - pt. taken to CT via
litter, on mask assisted by
2 RN's [redacted]
0027 - pt. transferred [redacted]
to CMU, bed #2 [redacted]

(b)(6)-2

≈ 30 y/o male In_2: (EPW) - seen Runn_ to scene of the a
with renal motor Attch and was shot. seen @ CCo rel then

& 2 FSB (2) chest tubes, (2) units Blood, 1500 cc IVF.
(3) ~~Vessels~~ IV's / Ancef / Intubated / sedated / paralyzed / Transfered
to here 28 CSH. Pt Arrived via Aeromed.

A: Intubated - verified
B: (A) BS Equal
C: All Ext
D: paralyzed sedated
E: Hemo (-), BACK negative Except for bruise around the
size of a pencil Eraser (see diagram).

LABS / X-Ray / CT / Nature of Terrorist (b)(6)-2
TO OR c̄ Pr [redacted] for GSW c̄ Chest to
pneumothorax, pulmonary contusion

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS		INITIALS	1830	INITIALS [redacted]
NEURO	PUPILS					PERRL (R)	
	SENSORIUM					A&O, moves all extremities	
						follows commands, MSO4	
						@1.5mg/hr	
RESPIRATORY	RESPIRATORY PATTERN					Reg, even, unlabored	
	BREATH SOUNDS					CTA (B), slightly ↓ Q LLL	
	SECRETIONS					Ø	
						On 4L NC, SaO2 98-100%	
SKIN	COLOR					NFR	
	INTEGRITY					Drsg across clavicle, Q chest	
						CDI, Q chest tube drsg min drain	
IV SITE	LOCATION					(R) fem cordis, Q ankle	
	CONDITION					Ø s/s of infx, (R) fem infusion	
						D5½ NS ≡ 20 KCL @ 100cc/hr	
						MSO4 drip @ 1.5cc/hr	
GASTRO	ABDOMEN					Round, soft, nontender	
	BOWEL SOUNDS					(+) x 4 quads	
GU	URINE:					Foley to gravity	
	COLOR/CLARITY					Amber & sediment	
CARDIOVASCULAR	CARDIAC RHYTHM					SR-ST ≡ S1 S2 noted, +1	
						UE pulses, +2 LE pulses,	
						YP to Q chest cont. suction	

LEGEND

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

(b)(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] RN

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 19 NOV

(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

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE 19 NOV 00 | DX s/p GSW to ULE/scrotum | HOSPITAL DAY Day 4

VITALS	TIME	24	01	02	03	04	05	06	07	08	08	09	10	11	12	13	14	15
	BP Arterial Line																	
	BP Cuff			140/75	128/93	120/87	129/81	114/70	106/44		90/37	110/80	90/40	101/60	94/40	90/60	88/62	88/60
	Temperature			33.6	33.7	33.9	96.1		99.2				99.2			99.1		
	Pulse			46	65	68	74	97	84		79	86	78	88	95	88	87	
	Respiratory Rate			10	14	14	14	14	14		14	14	18	18	24	24	26	20
	O2 Sat			100	100	100	100	100	100		100	100	100	100	100	100	100	100
	FiO2			70	60	60	60	35			35	35	35	100	35	35	35	35
	mode													[redacted]				

INTAKE	TIME		01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	D5½NS c 20K				100	100	100	100	100	500	100	100	100	100	100	100	100	100	600
	1% PB							50		50			100						
	Versed				2	2	2	off	off	6	off	off	off	off	off	off	off	off	
	MSO4				2	2	2	2	2	10	2	off	off	off	1.5	1.5	1.5	1.5	8
	NS/BOLUS							800		800			200						
	TOTALS									1360									1200

OUTPUT		HOUR / TOTAL																		
	URINE					200	220/420	145/565	140/705	150	855	70	150/220	180/400	100/500	100/600	140/740	40/780	50	810
		sp gr																		
		S/A																		
	NG	OUTPUT												100						100
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	JP												100				80		180
		CT1																17		
		CT2					110			110				50				50		100
	TOTALS																			1198

POST-OP DAY

VITAL SIGNS									
	16	17	18	19	20	21	22	23	
	HR 78		91/50 90						
				87/64	95/63	97/66	101/62	98/62	
	115	88	95	92			99.0		
	24	22	26	92	86	83	80	85	
	100	100	98	25	23	20	20	21	
	4L	4L	4L	99%	100%	100%	99%	99%	
	NL	NL	NV	4L	4L	4L	4L	3L	
				NC	NC	NC	NC	NC	

INTAKE									
	16	17	18	19	20	21	22	23	8° T
	100	100	100	100	100	100	100	100	2100
	80							50	250
									60
	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	30
	100								2000

OUTPUT									
	50	50	50	46	34	32	60	65	
		10	80	196	230	262	322	387	2052
									100
OP	44		0						100
GI	8		3						20
GU	50		50					17	287

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME		0515							
	MODE		SIMV							
	F_IO_2		60							
	TV		750							
	RATE		14							
	PEEP		+5							
ABG	A	pH	7.37							
		PCO_2	36.9							
		pO_2	271							
	B	HCO_3	22							
		SAT	100							
	G	BASE	-3							

LABORATORY DATA										
	TIME									
	GLUCOSE		217							
	Na/K		138 / 5.6							
	Cl/CO_2		102 / 21							
	BUN/Cr		12 / 1.2							
	WBC/PLATELET		5.3 / 143							
	Hct/Hgb		34.7 / 11.6							
	Ca		7.1							

ACTIVITIES OF DAILY LIVING										
	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION	0400				
	TRACH CARE									
	ROM EXERCISES									

24° I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	
INTAKE	OUTPUT		
IV 4386	Urine: 2052		
po	NG 100	(5)16-2	
	Drains 407		
TOTAL 4386	TOTAL 2559		
BALANCE			

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS [redacted]	INITIALS	1820	INITIALS [redacted]
NEURO	PUPILS	Perrla 3mm brisk, A&O		(5)(6)-7	PERRL (B)	
	SENSORIUM	moves all extremities (L) Arm			A&O, moves all extremities	
		weak the other follows commands			follows commands, MS04	
		MS04 @ 1.5mg/hr			@ 1.5mg/hr	
RESPIRATORY	RESPIRATORY PATTERN	reg, even, unlabored, CTA			Reg, even, unlabored	
	BREATH SOUNDS	x2 ↓ (L) UL			CTA B ε ↓ (L) UL	
	SECRETIONS	95-100% 4L NC			(0)	
					SaO2 93%-97% on 5L NC	
					~~via~~ O2	
SKIN	COLOR	WNL, bruising to (L) chest, chest			NFR	
	INTEGRITY	tube drg, s/c/i, incisions			Drsg on clavicle (R) UC & (L)	
		clavicle, (R) chest cont. suction			chest tube sites (R) I	
IV SITE	LOCATION	(R) Fem cordis, (L)			(R) Fem cordis & (L) ankle	
	CONDITION	ankle, ∅ s/s of infx.			Patent s/s of infx (R)	
					cordis infusing D5½NS ε 20	
					KCL @ 100 cc/hr ε MS04 @	
					1.5 cc/hr	
GASTRO	ABDOMEN	Soft, rounded ∅ distended			Round, soft, nontender	
	BOWEL SOUNDS	bowel sounds X4 quads.			(+) X 4 quads	
GU	URINE:	Foley to gravity amber			Foley to gravity	
	COLOR/CLARITY	color, clear, (+) sediment			Amber & sediments	
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 ∅ ectopy +1 ue pulses			SR-ST ε S1 S2 noted, (0)	
		+2 LE pulses,			ectopy, +1 UE, +2 LE,	
					pulse	

LEGEND

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

(5)(6)-7

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 6M3

DEPARTMENT/SERVICE/CLINIC ICU

DATE 20 NOV 93

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

[redacted] (5)(6)-7

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE 20 Nov 03 | DX | HOSPITAL DAY

VITALS SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line								~~97.4~~										
BP Cuff	104/63	107/69	108/68	108/68	106/66	108/68	97/65	97/64		103/64	104/70	104/69	108/70	104/62	108/57	104/62	100/57	
Temperature					100.8			97.4					98.4					
Pulse	86	84	85	96	86	92	96	88		91	90	87	98	93	89	93	96	
Respiratory Rate	21	21	23	26	26	26	24	20		24	26	24	25	20	20	30	21	
SaO2	97%	98%	94	93%	96%	97%	95%	98		97	100%	99	95	93	97	95	94	
FiO2	2L	2L	2L	2L	4L	4L	4L	4L		4L	4L	4L	4L	4L	4L	5L	5L	
Mode	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
D5½NS c 20KCl	100	100	100	100	100	100	100	100	800		100	100	100	100	100	100	100	1600
IVPB							50		50			100				50		200
MgSO4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	12	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	24
Blood Products											350		350					700
TOTALS																		

OUTPUT																			
URINE	HOUR	60	60	80	70	90	100	90	40		50	40	80	120	120	60	100	80	
	TOTAL		120	200	270	360	460	550	590	590		90	170	290	410	470	570	650	1240
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP							40											
	CT1							55											
	CT2							75											
TOTALS																			

590
650
1240

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	105/58	109/63	113/61	106/59	107/66	116/64	114/62	103/62	
				99.6					
	89	98	100	92	89	91	89	81	
	19	23	20	22	23	24	25	20	
	93	92	93	95%	98%	98%	96%	96%	
	5L	5L	5L	5L	5L	5L	4L	4L	
	NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE	16	17	18	19	20	21	22	23	8° T
	100	100	100	100	100	100	100	100	2400
								50	250
	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	36
									700
									3386

OUTPUT									
	120	125/255	70/325	60/385	70/455	80/535	80/615	80/695	1935
			35						75
			24						79
			125						200
									2294
									2584

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

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

TURN	TIME				
SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	3386	Urine:	1935
po		Drains	359
TOTAL	3386	TOTAL	2294

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
(5)161-2	

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

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL [redacted] ASSESSMENT

	TIME	0715	INITIALS [redacted]	INITIALS	1830	INITIALS [redacted]
NEURO	PUPILS	PERRLA @ 2.3mm			PERRLA (B)	
	SENSORIUM	Alert & oriented			A&O, moves all extremities	
		MAE, some difficulty			QUE = difficulty, MAE	
		moving (L) UE			@ 2.0mg	
RESPIRATORY	RESPIRATORY PATTERN	Even, unlabored			Reg, even, unlabored	
	BREATH SOUNDS	Shallow.			CTA (B), Q LL slightly ↓	
	SECRETIONS	BS in all lobes			Rales into tissue	
		clear to diminished			CT x 1 to H2O seal, 3L O2	
		w/ secretions			via NC	
		CTX2				
SKIN	COLOR	NFR, pulled to			NFR	
	INTEGRITY	L upper chest, IP			incision @ clavicle w/ s/s of	
		to bulb to suction			infx, IP to bulb sx	
IV SITE	LOCATION	(R) forearm, cordis			(R) Fem cordis, (R) ankle	
	CONDITION	(R) plump, area.			Patent, cordis infusing	
		w/ s/s of infiltration			D5½NS c 20 KCl @ 125/hr	
		(L) clear.			(L) ½NS @ 2 ml/hr, Heparin	
					@ 14 ml/hr	
GASTRO	ABDOMEN	Soft, mute, slow			Round flat nontender	
	BOWEL SOUNDS	BS x 4 quads			(+) x 4 quads	
GU	URINE:	Foley to gravity			Foley to gravity	
	COLOR/CLARITY	Amber			amber, slight sediment	
		cloudy urine.				
CARDIOVASCULAR	CARDIAC RHYTHM	S & S2 noted			SR-ST = S1 S2 noted	
		⊖ PVCs ⊖ ectopy			⊖ ectopy, +1 pulses UE,	
		+ pulses, cap			+2 pulses LE	
		refill 2-3 sec				

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

(b)(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] MGMS

DEPARTMENT/SERVICE/CLINIC: ICU #3

DATE: 21 Nov 03

[redacted] 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

DATE | DX | HOSPITAL DAY

VITALS SIGNS																	
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line																	
BP Cuff	103/54	106/61	117/63	106/62	121/65	117/67	112/69	124/79		113/69	110/65	106/65	110/63	126/70	125/70	117/71	119/66
Temperature	99.8																
Pulse	81	84	92	87	97	97	104	93	96	96	93	82	89	95	92	91	85
Respiratory Rate	21	24	28	22	29	26	28	27	25	25	24	21	21	30	27	26	27
SaO2	96%	95%	94%	93%	93%	92%	98%	94	92	92	94	96	97	95	93	93	95
FiO2	4L	4L	4L	4L	5L	5L	10L	5L			4L	4L	4L	6L	4L	4L	4L
Mode	NC	NC	NC	NC	NC	NC	NR	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
D5½NS+20KCL	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	1600
NaSO4	1.5	1.5	1.5	2.0	2.0	2.0	2.0	3	15.5	3	3	2	2	2	2	2	2	33.5
IVPB							50		50			100						150
Heparin																		
TOTALS																		

OUTPUT																		
URINE	HOUR	120	150	120	140	130	120	135	120		80	70	130	130	140	70	100	200
	TOTAL		270	390	530	660	780	915	1035		80	150	280	400	540	610	710	910
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	JP						0											
	CT1						22											
	CT2						60											
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	114/74	109/67	110/70	109/66	119/50	113/68	113/68	106/63	
								99.3	
	90	85	87	86	86	97	91	83	
	24	26	22	25	24	27	24	24	
	96	96	97	93%	93%	93%	93%	96%	
	5L	3L	3L	3L	3L	3L	3L	3L	
	NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE	16	17	18	19	20	21	22	23	8° T
	100	100	100	100	100	100	100	100	2400
	2	2	2	2	2	2	2	2	49.5
	50							50	250
	14	14	14	14	14	14	14	14	112

OUTPUT	16	17	18	19	20	21	22	23	
	150/150	180/330	200/530	280/810	270/1080	250/1280	100/1380	185/1565	3510
		160							22
		160							220

ACUITY LEVEL CLASSIFICATION

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

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

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

24° I&O TOTALS	NURSE'S SIGNATURE	INITIALS
wt Yesterday: ____ wt Today: ____	[redacted]	
INTAKE: IV 3257; po ____	OUTPUT: Urine: 3510; Drain ____; CT 242	
TOTAL 3257	TOTAL 3752	
BALANCE -495		

(5)(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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0645	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	Pend - 3mm, brisk, A/O		Sed/LA Pt alert to			
	SENSORIUM	x3 moves all extremities		Person place able to move			
		(5) weakness right foot, MSO4		extremities LUE very			
		@ 2.0mg		painful c weakness MSO4			
				drip 2 mg/hr			
RESPIRATORY	RESPIRATORY PATTERN	Regular, unlabored		Reg even clear c			
	BREATH SOUNDS	BS clear, diminished to		diminished (L) lung bilat			
	SECRETIONS	(0) lg, clear secretions		(0) secretions NK @ 2 Uhr			
		CT x1 to ipo, 3L O2		keeping SATS 99%			
		NC sat 95-99%					
SKIN	COLOR	NAR, sutures (0) upper		NAR surgical incision			
	INTEGRITY	clear, JP to suction,		(1) sl bleeding area CT			
				tube to suction (0) left			
IV SITE	LOCATION	(R) femoral cath (0) ankle		(R) femoral cath CDI			
	CONDITION	intact, ø s/s of infection		Dressing (0) ankle			
				patent hep 20 mu/hr			
				IV D5½NS c 20K @ 100 ml/hr			
GASTRO	ABDOMEN	soft ø tender, ø distended		soft non tender BS			
	BOWEL SOUNDS	BS x4 (0) active.		+ x4 hypoactive (0)			
				5m BM shift			
GU	URINE:	foley to gravity, amber color		FTG amber colored			
	COLOR/CLARITY	(0) sediment		urine (0) sediment snow,			
				free from sediment.			
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2, ø murmur, +1 pulses		S1, S2 ø murmur, NSR			
		UE, +2 pulses LE,		+2 pedal pulse +2 (R) radial			
		edema (0) arms, good		(0) radial difficult to assess			
		CR < 3 secs.		(0) long capillary refill 2 sec			
				pt ept LUE slow.			

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

(b)(6)-2

(Continue on reverse)

PREPARED [redacted] RN

DEPARTMENT/SERVICE/CLINIC: ICU 3 / Pstm

DATE: 22 Nov 3

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

(b)(6)-7

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE	DX													HOSPITAL DAY				
VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	92/45	114/65	109/69	115/68	108/66	111/64	103/70	112/71		114/78	110/74	113/72	115/72	114/75	115/71	116/74	115/70	
Temperature							98.6											
Pulse	75	81	72	75	89	77	83	81		72	73	67	84	88	83	80	81	
Respiratory Rate	23	21	24	19	23	22	20	20		21	19	22	14	22	23	21	20	
SaO2	97%	95%	94%	96%	94%	96%	94%	99%		95%	98	99	94	94	95	97	97	
FiO2	3L	3L	3L	3L	3L	3L	3L	3L		3L	3L	3L	RA	2L	2L	2L	2L	
Mode	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	RA	NC	NC	NC	NC	
INTAKE																		
TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
D5½NS&20KCL	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
MSO4	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	16	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	16
Heparin	14	14	14	14	14	14	14	14	112	14	14	20	20	20	20	20	20	148
NPB							50		50			100				50		200
PO																		
TOTALS									978									1164
OUTPUT																		
URINE HOUR	170	140	200	200	200	160	132	280	1582	50	100	120	40	20	180	200	240	1520
URINE TOTAL		310	510	710	910	1070	1202	1482		50	150	270	310	330	1080	1280	1520	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS JP																		
DRAINS CT2							20											
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	120/75	123/73	123/73	120/72	117/70	125/72	107/67	119/72	
				99.3			99.2		
	82	81	78	83	78	90	78	76	
	23	21	19	22	20	20	22	19	
	97	95	96	96	96	97	97	97	
	2L	2L	2L	2L	2L	2L	2L	2L	
	NC	NC	NC	NC	NC	NC	NC	NC	

INTAKE	16	17	18	19	20	21	22	23	8° T
	100	100	100	100	100	100	100	100	800
	2.0	2.0	2.0	6	2	2	2	2	20
	20	20	20	20	20	20	20	20	160
							50	50	50
			300cc						
									1030

OUTPUT	16	17	18	19	20	21	22	23	
	100/100	200/300	100/400	110/510	140/710	140/900	190/1090	100/1190	1190
		80							

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

ACTIVITIES OF DAILY LIVING	TIME	1530		
	MOUTH CARE	✓		
	BATH	✓		
	SKIN CARE	✓		
	FOLEY CARE	✓		
	TRACH CARE	/		
	ROM EXERCISES	✓		

TURN	TIME				

SUCTION	TIME				

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3172	Urine:	4292
po	300	CT	100
TOTAL	3472	TOTAL	4392

BALANCE -920

NURSE'S SIGNATURE [redacted] INITIALS

(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

INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

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

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	1800	[redacted]		INITIALS
NEURO	PUPILS	Round REACTIVE, accommo-		Pearl 3 m			
	SENSORIUM	TO LIGHT RESPONSIVE TO		Alert & 3 -			
		VERBAL & GOALS		Able to move All Extremes			
		STIMULI A & O x 2		UE LE follows verbal			
				commands			
RESPIRATORY	RESPIRATORY PATTERN	BILATERAL CHEST INS.		Reg eum			
	BREATH SOUNDS	DIMINISHED IN LOWER		Diminished in Lower			
	SECRETIONS	LOBES CHEST TUBE —		Lobes CT TO (D) side			
		BLOOD TINGED		tubes seal - draining			
		(D) SIDE - INSERTION		dk red bloody drainage			
SKIN	COLOR	NORMAL PIGMENTATION		WNL			
	INTEGRITY	SWELLING (D) ARM - UPPER		(D) ARM swollen incision			
		INCISION SUTURED (D) CHEST		upper (D) chest sutures intact			
IV SITE	LOCATION	(D) LEG		L arm (D) leg			
	CONDITION	WARM - WARM -		(R) Fem A-line - both patent			
GASTRO	ABDOMEN	BOWEL SOUNDS PRE-		~~both~~ Bowel soft NT			
	BOWEL SOUNDS	SENT - PALPABLE!		BS (+) X4 quads			
GU	URINE:	YELLOW - FOLEY		Yellow clear/foley			
	COLOR/CLARITY	CLEAR					
CARDIOVASCULAR	CARDIAC RHYTHM	S, S2 PRESENT.		S, S2 NSR			

LEGEND

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

(b)(6)-2

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] 9LUM 6

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 23 NOV 03

[redacted] *written entries give: Name—last, first, [redacted] medical facility)*

[redacted] (b)(4)-4

☐ HISTORY/PHYSICAL ☑ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

DATE 23NOV03 | DX GSW To Chest | HOSPITAL DAY

VITAL SIGNS																		
TIME	2400	0100	0200	0300	0400	0500	0600	0700		800	900	1000	1100	1200	1300	1400	1500	
BP Arterial Line																		
BP Cuff	128/67	100/57	100/68	117/71	117/68	113/72	116/70	114/70		99/65	116/69	121/68	128/56	119/69	117/78	117/76	116/69	
Temperature		99.3												98.6				
Pulse	80	82	75	72	78	74	74	67		77	69	75	73	81	73	67	81	
Respiratory Rate	12	21	18	19	19	21	19	20		20	18	18	15	16	20	13	24	
O_2	98	96	97	97	97	97	96	98		97	98	97	95	92	96	94	96	
MODE	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC	2L NC		2L NC	2L NC	2L NC	NC 2L	NC 2L	NC 2L	NC 2L	NC 2L	

INTAKE																		
TIME	2400	0100	0200	0300	0400	0500	0600	0700	8° T									8° T
IVF	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
IVPB							50		50			100				100		150
MSOY	2	4	2	2	4	2	2	2	20	2	2	2	2	2	2	2	2	16
HEPARIN	20	20	20	20	20	20	20	20	160	20	24	24	24	24	24	24	24	188
Juice								25	25									50
H_2O																		
TOTALS									1035									1154

OUTPUT																		
URINE	HOUR / TOTAL	200 /	160 / 360	90 / 450	100 / 550	160 / 710	200 / 910	160 / 1070	130 / 1200	1200	140 / 140	130 / 270	170 / 440	165 / 605	285 / 890	130 / 1015	60 / 1075	80 / 1155	1155
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	CT							80	20	100	15		5	10		10		20	60
TOTALS										1380									1215

POST-OP DAY

VITAL SIGNS	1600	1700	1800	1900	2000	2100	2200	2300	
BP	118/69	107/70	119/71	110/70	122/70	128/74	114/73	111/69	
T	98.7		97	97.2					
P	78	88	83	88	78	76	81	75	
R	20	26	23	27	34	22	23	19	
O2	2L	2L	2L	2L	2L	2L	2L	2L	
MS	NC	NC	NC	NC	NC	NC	NL	NC	

INTAKE	1600	1700	1800	1900	2000	2100	2200	2300	8° T
IV	100	100	100	100	100	100	100	100	800
	2	2	3	4	4	4	4	4	27
	24	24	24	24	24	24	24	24	192
		50					50		100
	50				100				150
PO							50		50

OUTPUT	1600	1700	1800	1900	2000	2100	2200	2300	
	192/192	80/282	190/472	140/612	200/812	120/932	135/1067	140/1207	1207
	15	5	10			1	5		36

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

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

24 H I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted]

(5)(6)-2

24 NOV 03

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	[redacted]	1900	[redacted]		INITIALS
NEURO	PUPILS		3mm brisk perrla		3mm brisk perrla			
	SENSORIUM		moves all ext; follows commands responds to questions alert		pt able to move all extremities follow commands. assist to turn			
RESPIRATORY	RESPIRATORY PATTERN		even, unlabored		even unlabored pt			
	BREATH SOUNDS		shallow, BS ↓ LLLobes. (+) cough		SATS 95-98 on 2L ↓ LLL diminished			
	SECRETIONS		CTA (B); diminished no secretions noted at this time.		no secretions so far this shift			
SKIN	COLOR		NFR		NFR incision (L)			
	INTEGRITY		incision (R) upper chest and (R) flank		upper chest OTA fine s/s infection LT flank CDI			
IV SITE	LOCATION		(R) fem. Cath		(R) fem cath - mod, clear			
	CONDITION		(R) chest: ↓redness swelling noted		(R) chest - 24 cathet. (+) swelling free s/s infection			
GASTRO	ABDOMEN		Soft, nontender, BS (+)		Bladder palpable			
	BOWEL SOUNDS		24.		pain upon palpation bowel sounds (+) hyperactive no BM this shift			
GU	URINE: COLOR/CLARITY		FTG, clear yellow urine, gs 150 mg/hr		Bed side urinal foley pulled @ 1700			
CARDIOVASCULAR	CARDIAC RHYTHM		NSR, ectopy (+) pulse RUE, (+) pulse ↓ (+) pulse LLE, (+) pulse LLE ↓ LLE swollen, warm; capillary <3 sec.		NSR ∅ ectopy, radial pulse palpable (+) dorsal pulses palpable skin temp cool cap refill 3-5 sec			

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE 24 NOV 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